DOCUMENT RESUME

ED 241 134 PS 014 143

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TITLE	Caring for Special Children: Independent Study Course for Child Caregivers.
INSTITUTION	Greater Minneapolis Day Care Association, MN.
SPONS AGENCY	Office of Special Education and Rehabilitative Services (ED), Washington, DC. Div. of Personnel Preparation.
PUB DATE	82
GRANT	G008102573
NOTE	215p.
AVAILABLE FROM	Greater Minneapolis Day Care Association, 1006 West Lake Street, Minneapolis, MN 55408 (Booklet and tape, $15.00).
PUB TYPE	Guides - Classroom Use - Materials (For Learner) (051)
EDRS PRICE	MF01/PC09 Plus Postage.
DESCRIPTORS	Audiotape Cassettes; *Child Caregivers; *Day Care; *Disabilities; Early Childhood Education; Independent Study; Inservice Teacher Education; Learning Activities; *Mainstreaming; *Preschool Children

ABSTRACT

This document describes an activity-based, independent-study, introductory survey course intended to help child caregivers in caring for mildly to moderately handicapped children in day care settings. Course materials consist of an audiotape cassette and a supplementary handbook; the handbook and a transcript of the audiotape are included in the document. Contents of the course are organized in 14 sections focusing on the following topics: mainstreaming; special needs children; developmental delay; speech and language development; cognitive development; social and emotional development; low incidence handicaps; observing and recording behavior; goal setting; task analysis; the learning environment; involvement with parents; and considerations regarding referrals, legal responsibility, and community resources. The audiotape provides definitions of basic concepts, general information about development, and guidelines, additionally describing specific techniques for responding to the needs of handicapped children. Each section of the handbook provides handouts and activity sheets and is coordinated with a segment of the cassette tape. (RH)

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Greater Minneapolis Day Care Association

Caring for Special Children

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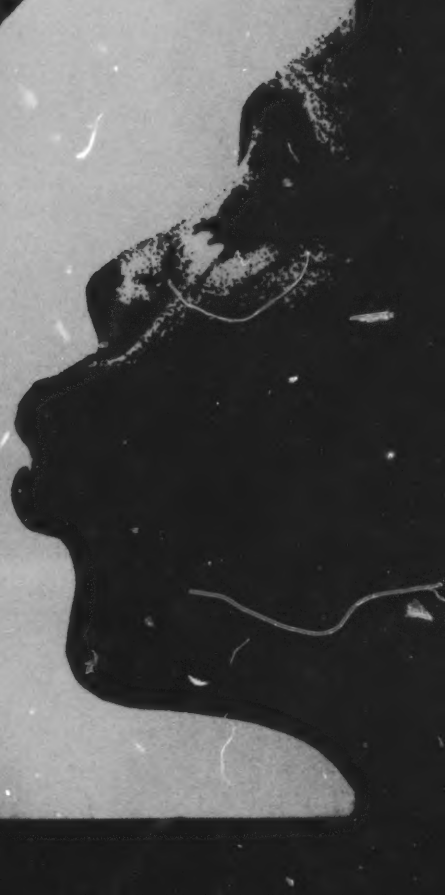
Independent Study Course for Child Caregivers



SERVING THE

SPECIAL NEEDS CHILD

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INTRODUCTION

The child care provider is often the first person to recognize a problem in the development of a child. Parents rely on their provider for accurate information about their child's growth and for assistance in dealing with concerns.

This course was written to give child care providers a basic understanding of caring for special needs children. It includes material on how to recognize a special needs child, talking to parents and techniques in working with children.

The children included in the term "special needs" are mildly to moderately handicapped. They have delays in their development in one or more areas. A delay may be in a specific area such as social-emotional or caused by a physical handicap, for example a hearing impairment.

This course is organized into fourteen sections. Each section has an accompanying cassette tape segment. The first page of each section indicates the order of information in that section. Most of the sections include activities to assist you in understanding the material.

SERVING THE SPECIAL NEEDS CHILD

COURSE OUTLINE

Introduction

Pt. 1 - Mainstreaming

Pt. 2 - Special Needs Children

Pt. 3 - Developmental Delay

Pt. 4 - Speech and Language Development

Pt. 5 - Cognitive Development

Pt. 6 - Motor Development

Pt. 7 - Social and Emotional Development

Pt. 8 - Low Incidence Handicaps

Pt. 9 - Observing & Recording Behavior

Pt. 10 - Goal Setting

Pt. 11 - Task Analysis

Pt. 12 - Environment

Pt. 13 - Parents

Pt. 14 - Referrals/Legal Responsibility/Community Resources

Conclusion

Acknowledgements:

This training course was made possible by the contributions of many individuals. Special thanks goes to Sharon Katz-Weintraub who planned, wrote and edited the majority of this book, Beth Koskie who was instrumental in organizing this book into its final format, and Nancy Olson whose hours of typing brought this all together.

Cover Design: Mary Jennings
Tape Read By: Steve Doyle

We would like to thank the following sources for materials used and adapted.

Early Childhood: Exceptional Educational Needs Project, Teaching Early Childhood Exceptional Educational Needs, Ten Resource Modules, Editor: Marshall E. Poole, Bulletin #8439, Wisconsin Department of Public Instruction, Barb Thompson, Ph.D., State Superintendent.

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"Pinpointing Teacher Goals to Assist in a Successful Preschool Classroom", by L. Jennifer Ashton-Lilo, M.A., Topics in Early Childhood Special Education, April, 1981.

Inventory of Language Abilities, Esther H. Minskoff, Douglas E. Eiscman, and J. Gerald Minskoff, Educational Performance Associates, Ridgefield, N.J. 07657, 1972.

Mary Jennings, Socio-Emotional Section.

Handouts used in this book were developed by the following individuals:

A. Yvonne Mendenhall - Trainer

Sally Kilmer - Family Day Care Training Project

Ann Carlson - Trainer, Family Live Educator

Linda Rees - Master Teacher, Speech Clinician

Foreword:

Caring for Special Children is a training project for those who care for special needs children in nursery schools, day care centers, or family day care homes. The project was developed through a three year federal grant from the U.S. Office of Education, Division of Personnel Preparation and supplemental funds from General Mills and the Nevin Huestad Foundation for Handicapped Children. Administered by Greater Minneapolis Day Care Association (GMDCA), the program focuses on training caregivers in every role: directors, teachers, specialists, assistants and family day care providers. Three levels of training options are available. Classes ranging from 3 hours to 10 hours provide an overview of basic areas of concern in caring for the special needs child. Workshops offer a two hour in-depth look at specific issues, concerns, or skills. And finally, an individually arranged guided field experience for 10 weeks with a Master Teacher is an opportunity to receive one-to-one, on-site training. This unique training addresses the caregivers teaching style, curriculum plan, environment and group make-up. The focus is on an individual child's special needs.

This handbook and tape was developed to be used as an independent study guide for individuals interested in the material covered in the 10-hour overview class. It includes material on how to recognize a special needs child, how to talk to parents, and suggested techniques for working with children. Completion of this guide and activities prepare the individual for the guided field experience.

The handbook and tape offer theory and practical application. Topics include general information concerning special needs; specific developmental milestones and when to be concerned; suggestions and forms for collecting information, goal setting and task analysis. Ages addressed are from birth through the pre-school years, however, caregivers working in special needs after school care have found the information helpful.

It is our hope that this information will provide practical guidance for caregivers of the special child.

Laurie Hestness
Project Director
Special Needs Project

These materials were developed, in part, with funds provided by the Division of Personnel Preparation Special Education Programs through Grant #G008102573. The views presented are those of the authors, and do not necessarily represent the official position of the Division of Personnel Preparation. Materials may be re-copies with credit given.

PART I - Mainstreaming

I. Tape

II. Handout 1A - Mainstreaming

III. Activity 1B - Criteria for Mainstreaming

IV. Handout 1C - Encouraging Positive Interactions

DEFINITION OF MAINSTREAMING

Mainstreaming means including children with special needs into regular group settings with other children who are developing at age level.

Mainstreaming's aim is to provide the special needs child with a "normal learning environment" which can offer him/her an equal opportunity to learn and develop to his/her full potential. However, the special needs child will require more help.

MAINSTREAMING CONSIDERATIONS

Question To Ask:

1. What is the extent of the child's delay? What areas of development are delayed?
2. Does the group have something to offer the child, and the child something to offer the group?
3. Does the day care environment recognize and meet the individual needs of all children?
4. What kinds of special training will care givers need to be able to meet the needs of the mainstreamed child?
5. What kinds of "curriculum" may need to be stressed for the special needs child, and to what extent can the setting provide that?
6. Will additional adults be needed to accomodate this child in the environment, and if so, is this feasible?
7. What kinds of coordination with other professional agencies and parents will need to take place, and how will this be done to plan for the child?

MAKING THE DECISION TO ENROLL A CHILD

Under each heading list some of the things you need to consider when deciding whether the placement will be appropriate or not.

A. CHILD - Will the child fit into the group?

Advantages to the Child

Disadvantages to the child

B. GROUP - Is the group appropriate for the child?

Advantages

Disadvantages

C. ENVIRONMENT

D. CURRICULUM

E. STAFF

F. SUPPORT SERVICES

Worksheet 1B

Answer Sheet

A) Child

1) What is the extent of the delay? (Mild Severe)
2) What developmental areas are delayed?
3) Does child have something to offer the group?
4) Has there been a medical exam, screening, or assessment? What do we know about the family background or the child's past history?

Advantages to the Child:

1) Normal learning environment
2) Challenges from peers and normal models
3) Opportunity to learn independence
4) Normal models for learning communication skills
5) Learn how to function in a group setting

Disadvantages to the Child:

1) Day care setting unable to meet their needs alone - needs additional or another type of setting altogether

2) Not enough opportunity for individual attention available

B) Group

1) Does the group have something to offer the child?
2) Can regular activities/environment be adopted to meet the special childs needs?
3) Can individual needs be met in the group?
4) Consider the group size; Adult/Child ratio.
5) Can the group be divided into smaller groups to provide individual attention?

Advantages to the Group

1) Children will learn to accept differences in people and will become more sensitive to other children with problems.
2) Will have opportunities to help other peers.

Disadvantages to the Group

1) An extremely disruptive child may affect learning environment for the others.

C) Environment

1) Does the day care center/family day care home recognize and meet the individual needs of all children?
2) Are all children encouraged to learn at their own pace?
3) Do providers break down activities into smaller learning steps for the child to be successful?
4) Do you need any additional equipment or materials for the special needs child?
5) Is there an area with few distractions available if needed?
6) Do you have appropriate materials to enhance learning (eg. puzzles, blocks, books)
7) Does your environment allow for flexibility?

D) Curriculum

1) What kinds of learning are stressed?
(Exposing child to all major developmental areas is best!!)
2) Does your setting allow you to actively interact with each child in your care?

E) Staff

1) What kinds of special training will caregivers need? (Need to learn special techniques and new skills)
2) Will additional adults be needed to mainstream this child? Is this possible? Can a volunteer or a relative help? How much one-to-one time is needed?
3) What are your own attitudes about a special needs child?

Advantages: Mainstreaming can be a valuable growth experience. You will learn new teaching techniques, and will often gain experience in coordinating your efforts with others!

F) Support Services

1) What kinds of coordination with other is needed? (professional agencies, parents)
2) What are the community resources available?
3) How can you involve parents (absolutely necessary!!)

WHAT CAN A PROVIDER DO TO ENCOURAGE POSITIVE INTERACTIONS BETWEEN SPECIAL NEEDS AND NON-SPECIAL NEEDS CHILDREN?

1. Arrange with parents for special needs and non-special needs children to play together outside of school;

2. Individualize some of the daily activities for all children, not just the special needs children;

3. Create a safe environment so that children will feel comfortable relating to each other;

4. Explain individual differences to children in a positive way;

5. Read aloud books and stories that deal with differences;

6. Answer children's questions directly and honestly;

7. Reinterpret actions for children in observable terms; e.g., "his legs don't work very well," or "it's hard for him to hold your hand without squeezing it."

8. Encourage children to talk about another child's behavior, rather than labeling a child;

9. Encourage positive interactions between children based on a common interest or experience;

PART II - Special Needs Child

I. Tapes

II. Handout 2A

III. Activity 2B - True or False?

IV. Activity 2C - Book

Activity 2A

Special Needs Children:

- Perform below what is normally expected of children their age.
- May demonstrate a delay in one or more of the following areas:
  - " Cognitive
  - " Motor (large muscle and fine motor)
  - " Speech/language
  - " Social-emotional
  - " Neurological
  - " Other related developmental area (attention span)
- May be mildly, moderately, or severly delayed.*
- May at first appear to be "age-appropriate" (does not necessarily have an obvious visible handicap)
- Have problems which interfere with their ability to learn, solve problems, communicate, move around, play with peers, or respond to discipline, etc.
- Have some strengths and some special needs. For example, a child can be socially and emotionally immature (below age level), but his/her language will be appropriate for his/her age.
- Not all young special needs children will remain special needs children. With appropriate help some special needs children can catch up before they begin Kindergarten. Others will continue to need help.
- Need and will benefit from Early Intervention and Early Childhood Education!!
- Some special needs can be noticed from birth. Intervention <u>can begin</u> at infancy.

*Note: A significant delay is usually regarded as being a 25% delay of child's age level. For example, a four year old with only three year old skills in communication has one year or 25% delay.

**Over a period of years, research and intervention programs have shown the importance and success of working with special needs children at an early age.

Activity 2B

Please mark T(True) or F(False) after each Question. Then check your answers on page 12.

	T	F
1. All children with Special Needs will have a readily visible problem.		
2. Often we do not know the reasons or causes of child's developmental delay.		
3. A child with developmental delays in speech and language skills may have age-appropriate motor skills.		
4. All preschool children with special needs will continue to need help throughout their education.		
5. It has been shown that good quality care and early education can help prevent or lessen developmental difficulties.		

Activity 2C

Do 1 of the following activities

A) Read the book provided about special needs children in your packet to the children in your group 3-1/2 years and older.

Talk with them about it and then write down a description of your feelings about the discussion and what the children's reactions were like. Were their reactions positive? Negative? Shy? Withdrawn about the subject? How do they react to the special needs child in your center/home?

or

B) If you have younger children in your care, write about why you are interested in caring for special needs children. What got you started and how do you feel about it?

Activity 2B Answers

1. False - often it is difficult to tell immediately if a child has a handicap.

2. True - it is difficult to attribute a delay to one specific cause. Children may have a variety of possible reasons for a developmental delay or no obvious cause.

3. True - developmental delays can show up in just one or a few areas.

4. False - developmental delays in young children can often be changed if the child receives appropriate help.

5. True - research shows that early intervention with young children can prevent problems in later years

PART III - Developmental Delay

I. Tape

II. Handout 3A - Developmental Milestones

III. Activity 3B - True or False?

IV. Activity 3C - Developmental Delays

V. Handout 3D - Developmental Questionnaire

DEVELOPMENTAL MILESTONES
BIRTH TO ONE

GROSS MOTOR

Rolling.
Sits without support.
Crawls.
Pulls self to standing and stands alone.
Cruising.
Walks with assistance (holding adult's hand).
Rolls ball in imitation of adult.

COMMUNICATION SKILLS

Responds to speech by looking at speaker.
Responds differently to friendly or unfriendly, male or female voice.
Turns to source of sound.
Responds with gesture to hi, bye-bye, and up when these words are used with gestures.
Responds to "no."
Makes crying and non-crying sounds.
Babbles when alone or when spoken to.
Interacts with others by vocalizing after adult.
Communicates meaning by vocalizing in different ways (e.g. cry for hunger, cry when hurt).
Tries to imitate sounds.
Combines syllable, (e.g. ma-ma, da-da).

SELF-HELP SKILLS

Feeds self with cracker.
Holds cups with two hands. Drinks with assistance.
Holds out arms and legs while being dressed.

FINE MOTOR

Swats at toys.
Reaches, grasps, puts objects in mouth.
Transfers object from one hand to other hand.
Bangs toys together at midline.
Controlled release.
Picks things up with thumb and one finger (pincer grasp).

COGNITIVE SKILLS

Follows moving object with eyes.
Responds to and imitates facial expressions of others.
Responds to very simple directions (e.g. raises arms when someone says, "Come," and turns head when asked, "Where's Daddy?).
Copies simple actions of others (e.g. shakes head no, plays peek-a-boo, waves bye-bye).
Puts small objects in and out of container.
Recognizes differences among people. (Responds to strangers by crying or staring).

SOCIAL-EMOTIONAL

Smiles spontaneously.
Develops a sense of trust in their main cargivers.
Responds differently to stranger than to familiar people.
Responds to name by smiling, looking, & turning head.
Explores body with mouth & hands.
Enjoys exploring the environment using senses.
Shows moods, looks hurt, sad, happy, uncomfortable, angry, & shows preferences.
Claps hands, waves bye-bye in imitation of adult.
Grows aware of self, social approval and disapproval.

DEVELOPMENTAL MILESTONES
ONE TO TWO YEARS

GROSS MOTOR

Walks alone.
Walks backward.
Picks up toys from floor without falling.
Pulls toy, pushes toy.
Seats self in child's chair.
Walks up and down stairs when holding hands.
Moves to music.

COMMUNICATION SKILLS

Responds correctly when asked where, when question is used with a gesture.
Understands prepositions on, in, and under.
Follows request to bring familiar object from another room.
Understands simple phrases (e.g. "Open the door" or "Get the ball").
Follows 2 simple directions that are related (e.g. "Go to the table and get a cookie").
Says first meaningful word.
Uses single words along with a gesture to ask for objects.
Says successive single words to describe an event.
Refers to self by name.
Uses my or mine to indicate possession.
Has vocabulary of about 50 words for familiar people, common objects, and events (e.g. more and all gone).

SELF-HELP SKILLS

Uses spoon, spilling little.
Drinks from cup, one hand without help.
Chews food.
Removes shoes, socks, pants, sweater.
Unzips large zipper.
Indicates toilet needs.

FINE MOTOR SKILLS

Stacks 3 small blocks.
Puts 4 rings on stick.
Turns pages 2 or 3 at a time.
Scribbles; imitates vertical & horizontal strokes.
Turns knob.
Throws small ball.

COGNITIVE SKILLS

Imitates actions and words of adults.
Responds to words or commands with appropriate action (e.g. "Stop that." "Get down").
Matches two similar objects.
Names or points to familiar objects on request (e.g. "What is that?" "Point to the baby").
Recognizes difference between you and me.
Has very limited attention span.
Learns through own exploration.
Object permenance (one displacement).
Understand simple cause effect relationships.

SOCIAL-EMOTIONAL

Responds to no.
Distinguishes self from others.
Refers to self by name.
Imitates adults in simple tasks.
Plays with one other child, each doing separate activity.
Actively explores his/her environment.
Plays simple games with understanding.

DEVELOPMENTAL MILESTONES
TWO TO THREE YEARS

GROSS MOTOR

Kicks ball forward.
Runs forward well.
Jumps in place, two feet together.
Stands on one foot, with assistance.
Walks on tiptoes.

COMMUNICATION SKILLS

Points to pictures of common objects when they are named.
Can identify objects when told their use. (e.g. "What can we bounce?).
Understands question forms what and where.
Understands negatives no, not, can't, and don't.
Enjoys listening to simple storybooks and requests them again.
Talks in two-word phrases.
Gives first and last name.
Asks what and where questions.
Makes negative statement (e.g. "Can't open it").
Shows frustration at not being understood.

SELF-HELP SKILLS

Uses spoon, spilling little.
Gets drink from fountain or faucet unassisted.
Turns handle to open door.
Takes off coat.
Puts on coat with assistance.
Washes and dries hands with assistance.

FINE MOTOR

Turns pages singly.
Strings 4 large beads.
Holds crayon with thumb and fingers, not fist.
Uses one hand consistently in most activities.
Imitates circles, and straight lines.
Rolls, pounds, squeezes, and pulls playdough.

COGNITIVE SKILLS

Responds to simple directions (e.g. "Give me the ball and the block." "Get your shoes and socks").
Selects and looks at picture books, names and identifies several objects within one picture.
Matches objects that go together (e.g. if given cup, saucer, and bead, puts cup and saucer together).
Stacks rings on peg in order of size.
Recognizes self in mirror, saying, "baby" or own name.
Can talk briefly about what s/he is doing.
Imitates adult actions (e.g. housekeeping play).
Has limited attention span. Learns through own exploration and adult direction.
Is beginning to understand how things are used (e.g. spoon for eating) and how parts fit together (e.g. body parts).
Descriminates simple shapes(circle, triangle, square).
Has a mental image of things; can imagine objects and actions.

SOCIAL-EMOTIONAL

Plays near other children.
Watches other children, joins briefly in their play.
Defends own possessions; little social give & take.
Participates in simple group activity (e.g. sings, claps, dances).
Knows if s/he is a girl or boy.
Avoids simple hazards or dangerous situations (e.g. hot burner, busy streets).
Capacity for voluntary choice is weak; often chooses both.
Has mood changes.
Desire for sameness.
Often rigid & inflexible.

DEVELOPMENTAL MILESTONES
THREE TO FOUR YEARS

GROSS MOTOR

Runs around obstacles.
Walks on a line.
Balances on one foot for 5-10 seconds.
Pushes, pulls, steers wheeled toys.
Steers and pedals tricycle.
Uses slide without assistance.
Jumps over objects about 6 feet high, landing on both feet together.
Throws ball overhead.
Catches ball bounced to him/her.
Alternates feet going up and down stairs.

COMMUNICATION SKILLS

Begins to understand sentences involving time concepts (e.g. "We are going to the zoo tomorrow").
Understands size comparatives such as big and bigger.
Understands relationships expressed by if...then or because sentences.
Carries out a series of 2-4 directions that are related.
Understands when told, "Let pretend."
Talks in sentences of three or more words (e.g. "I see the ball." "Daddy sit on chair").
Tells about past experiences.
Uses "s" on nouns to indicate more than one.
Uses "ed" on verbs to indicate past events.
Refers to self using words as I or me.
Speech is understandable to strangers, but says some sounds incorrectly.

SELF-HELP SKILLS

Pours well from small pitcher.
Spreads soft butter with knife.
Buttons and unbuttons large buttons.
Washes hands unassisted.
Blows nose when reminded.
Uses toilet independently.

FINE MOTOR

Stacks 16 small blocks.
Drives nails and pegs.
Copies circle.
Imitates cross.
Manipulates playdough (e.g. rolls balls, snakes, cookies).
Begin to trace forms.

COGNITIVE SKILLS

Recognizes and matches six colors.
Can stack blocks or rings in order of size.
Draws somewhat recognizable picture that is meaningful to child. Names and briefly explains picture.
Asks questions for information (e.g. why and how questions requiring simple answers).
Knows own age.
Knows own last name.
Has short attention span.
Learns through observing and imitating adults, and by adult instruction and explanation. Is easily distracted.
Has increased understanding of how things are used (e.g. hand and foot as body parts).
Begins to be aware of past and present (e.g. "Yesterday we went to the park." "Today we go to the library").
Correctly answers if—then—questions.

SOCIAL-EMOTIONAL

Has developed a strong awareness to themselves as people.
Shows obvious interest in other children and interacts with them.
Forms social group with real conversations & real quarrels.
Begins to use "we" & "yes" more.
Shows understanding of feelings by verbalizing love, anger, sadness, laughter, etc.
Helps with household tasks or errands.
Shares toys.
Fears are common.
Creates fantasies in order to solve problems and cope with fears.
May resist adults as part of new feelings of independence.

DEVELOPMENTAL MILESTONES
FOUR TO FIVE YEARS

GROSS MOTOR

Throws ball overhand.
Walks backward toes to heel.
Standing broad jump.
Turns somersault.
Hops on one foot.
Skips.

COMMUNICATION SKILLS

Follows three unrelated directions in order of request.
Understands words used to compare (e.g. pretty, prettier, prettiest).
Listens to long stories.
Understands the sequence of events when told them (e.g. "First we have to go to the store, then we can make the cake, and tomorrow we will eat it").
Asks when, how, and why questions.
Uses models like can, will, shall, should, and might.
Joins sentences together (e.g."I like chocolate chip cookies and milk").
Uses phrases beginning with because and so.
Tells about a story, but may confuse facts.

SELF-HELP SKILLS

Cuts easy foods with a knife (e.g. hamburger patty, tomato slice).
Laces shoes.

FINE MOTOR

Cuts on line continuously.
Copies cross.
Copies square.
Attempts to own name.
Refines skills which emerged at ages 3 and 4.

COGNITIVE

Plays with words (creates own rhyming words, says or makes up words having similar sounds).
Points to and names 4-6 colors.
Matches pictures of familiar objects (e.g. shoe, sock, foot, apple, orange, banana).
Draws a person with 4-F recognizable parts, such as head, arms, legs. Can name or match drawn parts to own body.
Draws, names, and describes recognizable picture.
Rote to 5; by age 5 can count 10 objects correctly.
Knows own street and town.
Has longer attention span. Learns through observing and listening to adults as well as through exploration. Is easily distracted.
Has increased understanding of how things are used and how parts fit together.
Time concepts are expanding. Child can talk about yesterday or last week, about today, and about what will happen tomorrow.

SOCIAL-EMOTIONAL

Plays cooperatively with group of children.
Play groups have distinct leaders & followers.
Able to take turns.
Helps with errands or putting away toys.
Social dramatic play ("house," "doctor")
Delights in humor & exaggeration.
Usually able to settle quarrels without adult help.
Expresses fears in dialogue or play.
Communicates feelings (e.g. happy, sad, angry).
Wants to keep things s/he makes - shows pride.

Activity 3B

Please Mark T(True) or F(False) following each question. Then check your answers on page 22.

	T	F
1. A child with a developmental delay may have a significant delay in one or more of the following areas: cognitive, motor, speech/language, or social/emotional development.		
2. A 4 year old child with a 6 month delay in motor skills is considered to have a significant delay.		
3. A child's real age and developmental age are not necessarily the same in all areas.		
4. All children, including those with special needs, follow a predictable sequence of normal development.		
5. A child's delay in one area of development cannot affect development in other skill areas.		

Activity 3-C

Directions: Number the following developmental milestones in each area in the correct order (1 for the first, 5 for the last). Check answers on answer sheet on following page.

Gross Motor

A. Balances on one foot for 5-10 seconds.

B. Sits without support.

C. Runs forward well.

D. Skips

E. Walks alone.

Fine Motor

A. Throws small ball.

B. Cuts on line continuously.

C. Stacks 16 small blocks.

D. Swats at toys.

E. Holds crayon with thumb and fingers, not fist.

Speech and Language/Communication

A. Asks what and where questions.

B. Understands when told, "let's pretend".

C. Turns to source of sound.

D. Refers to self by name.

E. Asks when, how and why questions.

Cognitive

A. Follows moving object with eyes.

B. Draws, names and describes recognizable picture.

C. Imitates actions and words of adults.

D. Begins to be aware of past and present.

E. Matches objects that go together.

Social and Emotional

A. Plays cooperatively with group of children.

B. Plays with one other child, each doing separate activity.

C. Shows understanding of feelings by verbalizing love, anger

Activity 3B Answers

1. True - developmental delays may be in one area or in several areas, depending upon the child.

2. False - a delay has to be 25% or more to be considered significant; a 25% delay for a 4 year old would be a 1 year delay.

3. True - All children differ in some areas of development. For example, a "normal" 4 year old may display skills at a 4-1/2 year level in motor, 5 year level in language, and 4 year level in cognitive areas.

4. True - the pattern of development may be slower for a special needs child (& even periodically stagnate) but all children follow a predictable sequence of development.

5. False - many of the areas of development are closely linked to other areas, such as language & cognitive. A delay in one area may or may not affect other areas of development.

ANSWERS

Gross Motor

A. - 4
B. - 1
C. - 3
D. - 5
E. - 2

Fine Motor

A. - 2
B. - 5
C. - 4
D. - 1
E. - 3

Speech and Language/Communication

A. - 3
B. - 4
C. - 1
D. - 2
E. - 5

Cognitive

A. - 1
B. - 5
C. - 2
D. - 4
E. - 3

Social and Emotional

A. - 3
B. - 1
C. - 2

3D

HUMAN DEVELOPMENT CENTER
DEVELOPMENTAL QUESTIONNAIRE
BACKGROUND INFORMATION

This is an example of a questionnaire used to evaluate a child's development and the factors which contribute to it. Please review, looking at the variety of information that can be collected which may influence a child's development

1. IDENTIFICATION

NAME_____SEX__RACE___DATE_____

BIRTHDATE_____AGE_____# of BIRTH CERTIFICATE_____

ADDRESS_____PHONE_____WHERE BORN_____

SCHOOL_____CITY_____COUNTY_____

DISTRICT NO._____TEACHER_____GRADE_____

VERIFIED BY_____MARITAL STATUS OF PARENTS_____

NAME OF FATHER_____ADDRESS_____

FATHER'S OCCUPATION_____WHERE BORN_____

NAME OF MOTHER_____ADDRESS_____

MOTHER'S OCCUPATION_____WHERE BORN_____

NAME OF STEP PARENT_____

SIBLINGS	AGE	GRADE

OTHERS LIVING IN HOME_____RELATIONSHIP_____

FAMILY KNOWN TO FOLLOWING SOCIAL AGENCIES (PLEASE ENCLOSE AGENCIES' REPORTS)

_____University Clinic _____Div. of Voc. Rehab.

_____Development Eval. Ctr. _____State Hospital

_____County Mental Health _____Other

_____Division Crippled Chn. _____

REFERRED BY_____ADDRESS_____

II. REASON FOR REFERRAL_____

_____

_____

_____

III. GENERAL DEVELOPMENT

PREGNANCY AND BIRTH HISTORY

What illnesses and/or accidents occured during pregnancy?_____

_____

Did mother have any miscarriages or stillbirths?___Length of Labor_____ _____Age of mother at child's birth___Any unusual problems at birth? If so, describe_____

Were drugs used?___Instruments___Were there bruise or abnormalities on child's head?___Other abnormalities_____Were drugs used during pregnancy? (If so, what were they?)_____

Birth weight_____Infant require oxygen?____Infant "blue" at birth? _____Jaundiced?_____Any health problems during first two weeks of life?(Describe)_____

_____At what age did infant regain birth weight?_____

DEVELOPMENTAL HISTORY

At what age did the following occur:

Held head erect while lying on stomach____Smiled____Sat alone unsupported_____Crawled____Walked unaided____Dressed and undressed self _____Fed self with spoon____Maintained bladder and bowel control while awake____While asleep____Had first tooth____Does child seem awkward or uncoordinated?_____Does child have chewing or swallowing difficulties?_____

Interview notes_____

_____

_____

_____

LANGUAGE HISTORY

Did child babble and coo during first six months?_____When did he use first words meaningfully (not in imitation)?_____Estimate how many works presently in child's vocabulary (check one) Under 25_____25 to 75_____ Over 75_____Has his vocabulary increased?_____Decreased?_____When did he began to use two-word sentences?_____Uses speech(check one): Frequently_____Occasionally_____Seldom_____Never_____ Prefers to communicate with (check only one): Gestures____Sounds_____One or two words_____ Phrases_____Complete sentences____

If he prefers gestures to speech give examples:_____

_____

How well is he understood by parents:_____

Brothers, sisters and playmates?_____

Others_____Does he look at family members when they are named?__ _____Does he point to common objects when asked "Show me the_____" or "Where is the___" _____Will he follow simple directions such as "Get me the____"?_____

IV. MEDICAL HISTORY

At what ages did any of the following illnesses or operations occur?

	AGE	SEVERITY		AGE	SEVERITY
WHOOPING COUGH			EARACHES		
MUMPS			RUNNY EARS		
SCARLET FEVER			CHRONIX COLDS		
MEASLES			HEAD INJURIES		
CHICKEN POX			VENERAL DISEASE		
PNEUMONIA			ASTHMA		
DIPTHERIA			ALLERGIES		
CROUP			CONVULTIONS		
INFLUENZA			ENCEPHALITIS		
POLIO			HIGH FEVERS		
HEADACHES			TYPHOID		
SINUS PROBLEMS			TONSILLITIS		
MENINGITIS			TONSILLECTOMY		
RICKETS			ADNOIDECTOMY		
RHEUMATIC FEVER			MASTOIDECTOMY		
CLEFT PALATE			KIDNEY DISEASE		

Describe any other operations the child has had_____

Where has he been hospitalized?_____When?_____
Name/Address of attending physician_____
Describe any serious illnesses he has had_____

Temperature_____Duration of high fever_____
Describe any deformities the child has_____
Have the child's eyes been examined?_____When?_____By Whom?_____
Results_____
Is the child now under special care of a physician?_____By Whom?_____
Is he now under special care of a dentist?_____Why?_____
Is he presently taking any medication?_____What?_____Why?_____

VIII. DIFFICULTIES IN SPECIFIC SKILLS: (Check)

VISUAL: confusion or reversal of letters_____confusion of words_____
choppy eye movements in reading_____poor eye focus in close work_____
in distant work_____other(specify)_____

AUDITORY: confusion of sounds_____difficulty in understanding conversation
_____difficulty in expressing ideas_____unable to produce rhythmic taps
or simple melody_____difficulty in memory_____
Other (specify)_____

VOCABULARY: limited_____misuse of words_____adequate_____
above average_____speech difficulty_____other (specify)_____

MOTOR SKILLS: difficulty in fine coordination_____in gross coordination
_____Other(specify)_____

VIII. DAILY BEHAVIOR (outside of school)

Does the child have a sleeping problem? (explain)_____
Eating problems? (explain)_____
Difficulty concentrating?_____If given a choice, does he tend to play alone, or with other children?_____Ages of playmates_____
How well does he get along with other children?_____
With adults?_____
Is it difficult to discipline the child? (explain as fully as possible)_____

Describe the child's favorite play activities_____

Describe any unusual behavior_____

Interview Notes:_____

EXPLAIN ANY OF THE ABOVE SECTIONS:_____

Language History continued

Please answer the following with a "yes" or "no" for each year.

	1ST YEAR	2ND YEAR	AFTER 2ND YEAR
Generally indifferent to sound			
Lack of response when spoken to			
Responded to noise and not voice			
Less than normal amount of crying			
Less than normal amount of laughing			
Hand banging or foot stamping			
Yelling or screeching to attract attention or express annoyance			
Marked alertness to gesture, facial expression, and movement			

Do you think he hears adequately?_____If not, what do you feel is the reason?

Does his hearing or speech appear to be constant or does it vary?_____
Is his hearing poorer when he has a cold?_____
Interview notes:_____

PART IV - Speech and Language

I. Review Handout 4A - Speech and Language Definitions

II. Tape

III. Handout 4B - Be Concerned If:

IV. Handout 4C - Some General Suggestions Regarding Communication

V. Handout 4D - Articulation Test

VI. Activity 4E - True or False?

VII. Tape

VIII. Handout 4F - Techniques for Stimulating the Speech and Language Development of Preschool Children

IX. Activity 4G - Language Stimulation (Blank tape cassette to be used.)

Handout 4A

Speech and Language Definitions

A. Receptive Language refers to the ability to understand what words mean or to get meaning from what people say to you.

B. Expressive Language refers to the use of language; verbal and non-verbal, talking and gesturing. It is a way in which we can communicate our thoughts and ideas to others.

C. Articulation is the term used to describe the production of speech sounds. It refers to the child's expression of meaningful language. Good articulation becomes most important when a child is trying to communicate real, meaningful words to us. When a child wants to tell us about some- or ask us for something, much frustration results if he has the language, but cannot be understood.

Types of Articulation Errors:

A. Omissions (e.g. "Bock/block", "bo/boat") very common in children under 3 years.

B. Substitutions (e.g. "toap/soap", "pish/fish") child uses sounds which is entirely different from what is considered correct. Child usually substitutes early developmental sounds for later ones.

C. Distortions - Child incorrectly produces a given sound, but gives a approximation of that sound. Although pronunciation is inaccurate, it can usually be understood. (e.g. whistling "s")

Handout 4B

SPEECH AND LANGUAGE DEVELOPMENT

*Remember: Watch for patterns of behavior!!

Be Concerned If:

1 year old

Is not vocalizing; babbling by 4-1[illegible] months
Is not beginning to say a few words
Is not responding to sounds or the speech of others
(e.g. Localizing sounds; responding to own name)

1 - 2 years

Is not engaged in much imitation (gestures and words)
Is not talking at all by 2
Is not labeling verbally, even with 1 word
Is not responding to simple "who", "what", "where" questions
Cannot follow simple verbal directions (e.g. "Get the Ball")

2 - 3 years

Is still using only single words
Is usually aggressive when expressing desires and uses little speech
Is constantly echoing speech, especially if inappropriate to the situation and beyond normal imitation (e.g echoing statements, songs, rhymes, commercials, etc.)
Is using gesturing as main way of communicating
Is using mostly vowels in speech at 2 years
Is omitting or is unable to imitate early developmental sounds at beginning of words (p, b, m, n, g, w, h)

3 - 4 years

3 year old can't follow simple directions or ask for something
Has difficulty answering simple questions "who, "what","where," "when", "why"
Asks for frequent repetitions of information or directions
Has inability to put 2-3 word sentence together by age 3 or multi-word sentences by 4 years
4 year old still uses incomplete sentences
Has mostly unintelligible speech after 3 (even though speaking in 2 or more word phrases/sentences)
Is not correctly using early developmental sounds at the beginning and end of words

INFORMAL ASSESSMENT OF RESPECTIVE AND EXPRESSIVE LANGUAGE SKILLS

-- Four and Five Year Olds --

Receptive Language

Be concerned if child:

Doesn't correctly answer comprehension questions about a story which has just been read to him/her.

Has difficulty learning abstract words expected for age

Doesn't laugh at funny stories, nonsense rhymes, or silly language when other children generally do

Doesn't like to play verbal games with other children (e.g. playing store)

Often confuses different words with similar sounds (e.g. "pin" for "pen"; "busy" for "dizzy")

Not interested in hearing a story read from a book, but does like to look at accompanying pictures in book

Doesn't listen to other childern recite in "Show and Tell" or other such verbal classroom activities

Cannot follow a set of three related directions given orally

Has difficulty understanding what he hears on a phonograph, radio, or tape recorder

Is not interested in listening either to conversations between adults or between other children

Has difficulty identifying sounds or words in activities (e.g. the "b" sound in "boy" and "bat"

Can't tell how things or ideas he/she hears differ (e.g., the difference between a bike and a car)

Gives inappropriate answers to questions

Doesn't know simple opposites

Tells incoherent stories (i.e., stories that don't make sense to the other children)

Can't understand rules of new games when they are spoken

Can't associate a heard story with his own life experiences

Doesn't ask why or how; not interested in causes or relationships

Can't make simple associations presented orally (e.g., hat goes with coat)

Has more difficulty understanding the teacher when he/she moves around the room than standing still; needs to look closely at speaker's lips

Has difficulty understanding words sung in a song

4 - 5 years

Uses incomplete sentences or immature word forms (e.g. omits "is" or substitutes "me"/"I", "him"/"he")
Uses only short sentences
Cannot ask questions, follow group directions, answer questions
Has word finding problems
Has trouble following verbal directions
Omits, substitutes, or distorts early developmental sounds at the beginning or end of words
Has articulation errors 1 year delayed on other age-appropriate sounds
Doesn't correctly answer comprehension questions about a story just read
Gives inappropriate answers to questions
Tells incoherent stories (e.g. stories don't make sense to other children)
Can't understand rules of new games when spoken
Has difficulty formulating and organizing thoughts and putting thoughts into words
Uses inappropriate word order
Has difficulty describing pictures or experiences
Persevorates (repeats word over and over again inappropriately)
Hesitates, pauses, repeats self frequently

Expressive Language

Has difficulty describing pictures or experiences

Can't define simple words such as apple

Uses same words repeatedly; little variety in language usage; perseverates

Seems excessively shy and non-verbal

Has difficulty thinking of word to fit own idea; often uses vague words instead of specific words (e.g. "The thing on the desk" for "The crayon on the desk"). or words which do not fit idea he wants to convey

When he/she responds motorically, is usually correct; but when he/she responds verbally, is usually incorrect (e.g. points to correct picture, but gives wrong label for it)

Points to things rather than asks for them

Speaks in isolated words or sentence fragments, but not in complete sentences

Doesn't ask questions

Cannot converse with adults or children on common topics

Uses only a few short simple sentence structures

Deletes small words from sentences (e.g. "I have apple")

Uses possesives incorrectly (e.g., "This is him book.")

Uses pronouns incorrectly (e.g., "Me go.")

Uses questioning intonation in voice, but doesn't use question structure (e.g. "I go there?" and not "Can I go there?").

Doesn't use plurals correctly (e.g., "They drinks the milk")

Doesn't use past tense correctly (e.g., "I walk home," for "I walked home.")

Doesn't use negatives correctly (e.g., "I no like.")

Puts words in the wrong order (e.g., I got a truck big.")

REFERENCE:

Checklists taken from the INVENTORY OF LANGUAGE ABILITIES
by Esther H. Minskoff, Douglas E. Wiseman, and J. Gerald Minskoff
Educational Performance Associates Ridgefield, N.J. 07657 1972

Voice Problems (Chronic Voice Disorders)

*Are rare in preschoolers -

*Watch for: Pitch that is extremely high or low
Voice that is continually hoarse, harsh, raspy, strained.
Voice that is consistently too loud, too soft, or monotone (may indicate a hearing loss)
Abnormal rhythm, rate of inflection of speech
Hypernasal (sound coming thourgh nose) voice quality

If concerned, refer to doctor and/or Speech/Language Clinican

Stuttering

*Most 3-5 year olds repeat some sounds or words or clutter speech with a lot of "ush". This is usually done without tension, forcing or pushing words out. Such normal disfluencies are not considered stuttering. Usually if no one calls attention to it, it will go away.

Be Concerned if:

Child shows particular mannerisms when speaking (e.g. eye blinking, looking away, tapping fingers, twisting lips, stamping foot as forcing out words)

Child repeats the beginning sound or syllable of words quite frequently

Facial contortions present when speaking

Child nonfluent after 6

*Remember: Don't interrupt a child who is having difficulty speaking. Respond to what the child has said.

Don't say: "Slow down; Say it again".

If concerned, refer to a Speech/Language Clinican.

SOME GENERAL SUGGESTIONS REGARDING COMMUNICATION

1. Speak normally, clearly, and naturally with no exaggeration of lip or facial movements... Don't overreact to child's speech productions.

2. Be a good listener' listen and respond.

3. Adjust to child's eye level so he/she can see your face; when talking about something, you can hold the object beside your mouth as you say the word.

4. Allow child to enter conversations on their own, when possible, or by asking questions. Ask short simple questions.

5. Isolate key words; avoid multiple commands or directions when too difficult; use specific words, gestures, moving child through an activity.

6. Rephrase direction when repetition does not work.

7. In expanding and modeling, use what the child already knows.

8. Alter inflection, pitch, speaking rate, and volume of your voice to emphasize key words and emotional content of verbal message.

9. Note whether child needs cues to understand.

10. Adapt expectations and responses to particular child...get their attention first.

11. Break down skills; sequence activities (e.g., storytelling skills, child learns to label, answer questions, and then begin a story).

12. Note yes/no/sometimes regarding child's performance; task analysis.

13. Aim is the child's SUCCESS!

14. Be systematic...Watch for patterns.

15. Watch your pacing...Other children can help alert a child who is having problems to follow directions or give attention to the teacher.

16. Make sure there are quiet places in the room: give children with difficulty understanding and listening new information in a quiet area if possible.

17. Activity modifications; making simple drawings to add to storytelling, etc.

QUESTIONS TO ASK IF CHILD DOES NOT RESPOND WELL

DOES CHILD:

1. hear and see well?

2. discriminate well enough to respond to alternatives?

3. listen to (attend to) questions/comments requiring a response.
   *Watch for signs of lack of concentration, understanding, attention, auditory processing difficulties.

4. Is vocabulary sufficient enough so child can understand.

5. Does child remember long enough to respond.

6. Are we responding to their attempts to communicate.

7. *Has the child had the opportunity and experience of talking to many different people in a different settings.

8. Are we providing child with opportunities to talk (responding to developmental level of child) (more difficult to identify child who initiates very little speech or does not speak at all).

RESPONDING WHEN CHILD UNINTELLIGIBLE

WHEN INTERACTING WITH AN ARTICULATION DELAYED CHILD:

1. Learn to understand what the child says.

2. Ask the parents about names, favorite objects, etc.

3. Teach/give child practice in developing listening skills (auditory awareness and discrimination).

4. Work first on dissimilar sounds (auditorally or motorically); model.

5. Be honest; tell child you don't understand and ask him/her to tell or show you again (child will know if you respond inappropriately); May ask, "What?"

6. Do not force child to repeat remark you have understood.

7. If child says something incorrectly (word, sentence) restate it for him/her in positive way--'natural way': (i.e., "tee doggy" "Yes, I see a doggie" Tell child: "I like it when you tell me things")

8. Sometimes appropriate to accept child's non-verbal communication. Depends on number of factors (nature and degree of communication disorder). It is best for a child's nonverbal response to be accompanied by his/her best vocal utterance, even single sounds (e.g., "a" for "cat").

9. It is important for the child to decide what he/she is going to do when asked for clarification - Watch out-Try not to play "communication charades" often.

ARTICULATION TEST

NAME_____ DATE_____

sound	words						
m	monkey	hammer	comb				
p	pig	apple	cup				
b	ball	baby	bathtub				
w	window						
h	horse						
n	nose	banana	spoon				

75% of all children can say the above sounds by 3 - 3½ years of age

t	table	potatoes	boat				
d	dog	ladder	bed				
c	cow	cookie	cake				
g	gun	wagon	egg				
y	yellow	yes					
ng	swing						
f	fork	elephant	knife				

3½ - 4½ years

l	lamp	balloon	bell				
v	vacuum	T.V.	stove				
sh	shoe	gas station	fish				
ch	chair	matches	sandwich				
j	jar	angel	orange				
th	thumb	toothbrush	teeth				

4½ - 6½ years

sound	words						
s	saw	pencil	house				
z	zipper	scissors	keys				
th (voiced)	this	feather					
r	ring	carrot	car				
r (blends)	brush	truck	train				
er	bird						
l blends	blocks	clock	airplane				
s blends	spoon	star	nest				

6 - 7½ years

Place a T(True) or an F(False) after each statement. Check your answers on the back of this sheet.

	T	F
1. By five years of age, children have learned all the basics of language development. From 5 years on, children continue to refine the skills they've learned.		
2. If a child uses a word we can be sure that he understands its meaning.		
3. Children with chronic ear infections may also develop a delay in speech and language skills.		
4. When a child begins to consistently repeat the beginning sounds in words, we need to tell them to "slow down and try it again."		
5. A 3 year old child should be pronouncing the "s", "r", and "l" blends correctly.		
6. If a child says something incorrectly, restate it for her in a positive, natural way.		
7. Be concerned if a 4 year old child has difficulty describing pictures or experiences.		
8. Be concerned if a 3 year old uses gestures as his main way of communicating.		
9. Be concerned if a 2 year old cannot put 3 word phrases/sentences together.		
10. Be concerned if a 5 year old puts words in the wrong order.		

4E

Answers

1. True - the basics of language/communication have been learned by 5 years of age.

2. False - not always does a child understand the meaning of words they use, it is wise to check.

3. True - ear infections affect children's ability to hear, so it can affect their language development too.

4. False - this just calls attention to the problem and makes them more self conscious.

5. False - these are harder sounds to learn, and may not appear in speech until later.

6. True - this takes pressure off the child, but assures they hear language in the correct form.

7. True - by this age a child should be descriptive in his language development.

8. True - by this age a child should be using words as his/her major form of communication.

9. False - 2 year olds may still be using gestures & 1-2 word combinations.

10. True - if by 5 a child has learned the basic language system, then words should be in the right order most of the time.

TECHNIQUES FOR STIMULATING THE SPEECH AND LANGUAGE DEVELOPMENT OF PRESCHOOL CHILDREN

DEFINITIONS:

Receptive Language refers to the ability to understand what words mean or to get meaning from what people say to you.

Expressive Language refers to the use of language, verbal and non-verbal, talking and gesturing. It is a way in which we can communicate our thoughts and ideas to others.

General Suggestions:

1. Get down to the child's physical level. The child can miss so much visual contact. And it is more personal when you are on his/her level.

2. Get the child's attention before proceeding with instructions or conversation. Attention precedes understanding.

3. Use a quiet speaking voice. The child is more likely to respond favorably to normal loudness than to shouted commands.

4. Use a pleasant speaking voice. A pleasant voice has a calming, soothing effect.

5. Give your immediate response to the child. Immediate attention says to the child that you are interested in what he is saying.

6. Use reflexive responses, as opposed to impulsive, short, or angry answers. Even if you are angry with the child, a moment's pause may help you to think of a way to use your anger as a teaching tool, not just an emotion.

   Example: "What you just did made me angry. Do you know why I am angry?"

7. Use model language: full sentences; short sentences; non-complex sentences. "Baby talk" is definitely out. The child must hear a good language model several times before he can be expected to use it.

8. Speak slowly, but not with exaggerated slowness. Adult-level language can be very complex. A normal speaking rate gives the child more chances to interpret what you are saying.

9. Uses choices. Ask the child to choose between two items or alternatives rather than the usual "yes" or "no" questions.

10. Repeat your own words, phrases, and sentences. Repetition is one of the more useful techniques.

11. Expand the child's receptive language, not always expecting a reply from him/her. Keep the complexity of your language at a level where you believe the child can just absorb it. Keep introducing new concepts and new language.

General Suggestions: (Continued)

12. Allow time for an individual conversation with each child daily. This is her/her personal time with you, even if the amount of time must sometimes be short.

13. Keep manipulative objects in the room at all times. A bare room inspires little interest. Something that can be handled is more interesting than a poster on a wall.

14. Use reinforcement for more complex language, e.g., "I like to hear you say more words."

SPECIFIC SPEECH AND LANGUAGE STIMULATION TECHNIQUES

A. MODELING

In modeling, the adult provides a verbal example for the child to imitate. Modeling a single sound, word, or sentence often leads a child to self-correction. For very young children modeling would be simply providing labels for objects, people, and actions in their environment such as; Mommy, bottle, potty, puppy, ball, etc. As the child's language becomes more complex, so does modeling by putting words together to communicate meaningfully: I want Mommy, Bottle all gone, Go potty, Puppy is barking. For older children, this technique would include modeling a sentence that would help them change their own environment such as: "You can say 'tie my shoe'" (I want juice, It's my turn, etc.)

B. SELF-TALKING

When Self-talking, the adult describes an activity while performing it in the child's presence. Talk out loud about what you are hearing, seeing, doing, or feeling whenever the child is nearby.

Self-talking is centered around the concepts involved in an activity. Important words and phrases are often repeated several times. Self-talking is responsive to the children, the materials, and the actions involved. It is a way to provide children with language models they will later express on their own.

C. PARALLEL TALKING

When parallel talking, the adult describes to the child what that child is doing, seeing, feeling, or hearing at the moment or what he/she has just done. It is a way to offer words to a child who has minimal expressive language. Parallel talking helps to expand children's understanding of language and stimulates the development of their expressive language skills.

Example: While watching a child build with blocks - "You are building a road for the little cars. Now, you're making it longer. You made the road turn a corner. The road is really getting long. What a good idea! You're making a bridge. Now the cars can go under the bridge!

C. PARALLEL TALKING (Continued)

Answer-Question

While parallel talking you can often draw words from the child by making a statement and then asking the child to repeat it.
Example: Watching a child build with blocks.
Teacher: "Oh, oh! The bridge fell down. What happened to the bridge?"
Child: "Bridge fell down!"

D. QUESTION ASKING

One of the principal techniques that is used to encourage a child's expressive language is Question Asking. In Question Asking, the adult structures questions so that the child will be able to understand and respond.

Questions need to be constructed at the developmental level of the child's language comprehension skills. The two types of questions that can be asked are?

Close Ended Questions, which require the child to respond with a "yes" or "no" answer, and

Open Ended Questions, in which the child is required to respond in several words.

Open ended questions stimulate the greatest language expression from the child as opposed to "yes" or "no" type questions.

Using questions and phrases such as "What is happening?" "What do you want?", "What is he doing?", and "Tell me about it", encourage children to talk. This technique calls for more creative responses from the children. It also provides us with opportunities to expand upon the children's responses.

E. EXPANSION

When using Expansion, the adult elaborates and adds to what the child has said.

Expansion provides additional information to children. This technique can be used to provide new language models which children may later incorporate into their own expressive language systems.

Expansion is often used as a compliment to Question Asking. Whether children express themselves with single words or with short sentences, we can provide additional language models. Expansion is especially important when used with children delayed in expressive language skills.

Example: Child--"That's hot!"
Adult--"Yes, the stove is hot. And a fire is hot. Mommy's coffee is hot."

Self-Expansion

Stimulate the child to attempt to expand his/her own language by using such directives as "Say the whole thing." This technique can be useful when you are sure the child is capable of producing the full sentence.

E. EXPANSION (Continued)

Repetition-Expansion

Repeat what the child has said, making corrections in language in a very matter-of-fact way.

Example: Child--"Go downtown!"
Adult--"Yes, we are going downtown."

Extension

Adding new information to what a child says.

Example: Child--"I like grape juice."
Adult--"Yes, and sometimes we have orange juice instead of grape juice."

Correction

Instead of telling the child, "You said it wrong", you can repeat the child's utterance with corrections.

Example: Child--"Me want cookie."
Adult--"Yes, I want a cookie too."
Child--"Him have two ears."
Adult--"Yes, he has two ears."

F. PROMPTING

When prompting, the adult gives the child a verbal or non-verbal cue to elicit the desired response.

Prompting may involve pointing, pausing, or beginning a word or phrase to help the child respond. We can use Prompting with a single child or with an entire group.

Example: When pointing to a picture say "This is a _____", leaving off the end of a sentence for the child to finish.

Backward Chaining

This is similar to open-ended sentences, but occurs when you are reading a book, telling a story or doing a finger play. As children become more familiar with the words, you can leave off more and more words for them to fill in.

Example: When reading the book, Are You My Mother? After you have read this sentence once, the next time you leave off the last word, then the last two words, and so on. "Are you my ____?"; "Are you____?"; "Are____?"

4G

Language Stimulation

Tape Record a group activity in your center or home (e.g. Cooking, Art, Blockbuilding) Try to use as many Speech and Language Stimulation Techniques as you can during your interactions with the children.

Then listen to the tape and list below which techniques you actually used and examples of each.

Which techniques could you have used more? When would this have been appropriate?

Speech/Language Name of Technique Used	Example

PART V - Cognitive Development

I. Tape

II. Handout 5A - How Children Learn and Grow Intellectually

III. Review Handout 3A

Iv. Handout 5B - Cognitive Development
Be Concerned If:

V. Handout 5C - Possible Reasons for Cognitive Delays

VI. Tape

VII. Activity 5D - True or False?

VIII. Activity 5E

HOW CHILDREN LEARN AND GROW INTELLECTUALLY - PIAGET

1. Children have mental structures that are different from those of adults. They are not adults in miniature; they have their own distinct ways of determining reality and of viewing the world.

2. Children's mental development progresses through definite stages. Those stages occur in a fixed sequence - a sequence that is the same for all children.

3. Although the stages of mental development occur in a fixed order, different children move from one stage to another at different ages. Further, a child may function in one stage for some matters, while he functions in a different stage for other matters.

4. Mental development is influenced by four interrelated factors:

   a) Maturation - physical maturing, especially of the central nervous system.

   b) Experience - handling, moving, and thinking about concrete objects and thinking through processes involving them.

   c) Social interaction - playing, talking, and working with people, especially other children.

   d) Equilibration - the process of bringing maturation, experience and socialization together so as to build and rebuild mental structures.

5. Stages of mental development:

   a) Sensory - Motor (birth to 2 years)

      1. Birth to 2 months - through use and practice inborn reflexes become differentiated, precise and skilled.
      2. 2 to 4 months - reflexes coordinate and simple habits are formed.
      3. 4 to 8 months- through experimentation a child discovers what he can do with objects.
      4. 8 to 12 months - a child demonstrates behavior that is definitely intentional in character.
      5. 18 to 19 months - a child begins to experiment and search for new ways to solve his problems.
      6. 18 months to 2 years - a child invents new ways to solve his problems by some form of primitive mental activity.

   b) Pre-operational though (2 to 7 years)
      This stage begins when a child has the ability to solve his problems through some primitive form of mental activity and his language is developing. It is divided into two parts:

      1. Preconceptual thought (2 to 4 years)

         a) Begins to understand that all meaning consists of a relationship between a word and an actual object.

         b) Makes judgements about how objects look to him - said to be egocentric.

c) Abilities include:

1. categorizing things on the basis of single characteristics.
2. reasoning that if A is like B in one respect; than A must be like B in all respects.
3. thinking in preconcepts. He does not understand the nature of classes of things or class membership.

2. Intuitive thought (4 to 7 years)

a) Reasons and explains on the basis of intuitions hunches, instead of logic.

b) Abilities include:

1. thinking in terms of classes. Can classify on the basis of objective similarities (color, shape, etc.)
2. utilizing numbers and ordering things in terms of quantity.

c) Concrete Operations (7 to 11 years)

1. Developing the concept of number, relationship, process, etc.
2. Becoming able to think through problems mentally in terms of real (concrete) objects, not abstractions.
3. Developing greater ability to understand rules.

d) Formal Operations (11 to 15 years)

1. Can think using abstractions.
2. Forms theories about everything.
3. Very concerned with the possible as distinct from the actual.
4. Reaching the level of adult thought.

6. "Operations" are actions carried out mentally. Necessary for rational thought. Include:

a) Conservation - the recognition that a property such as number, length, or quantity remains the same in spite of changes in position, shape, or grouping.

b) Reversibility - the recognition that any change of position, shape, order, etc. can be reversed - returned to original position, shape, or order.

7. Children's mental development imposes definite limitations on what they can learn and on how (the conditions under which) they learn.

8. Thoughts grow from actions, not from words.

9. Knowledge cannot be given to children. It must be discovered and constructed through the learner's activities.

10. Children learn best from concrete experiences.

11. By nature, children are continually active. They must find out about and make sense of their world. As they do they remake the mental structures that permit dealing with even more complex information.

12. This remaking of mental structures makes possible genuine learning - learning that is stable and lasting. When necessary structures are not present, learning is superficial - not useable and it does not last.

COGNITIVE DEVELOPMENT

Handout 5-B

Be Concerned if:

By one year of age a child:

1. Does not respond to and imitate others' facial expressions.
2. Does not copy simple actions of others.

By two years of age a child:

1. Does not understand simple cause/effect relationships.
2. Does not imitate actions or words of adults.
3. Does not name or point to familiar objects on request, (e.g. "Where's Daddy?").

By three years of age a child:

1. Does not match objects that go together (e.g. cup/saucer).
2. Does not respond to simple directions (e.g. "Get your hat and coat.").
3. Cannot name a couple of body parts
4. Cannot identify several objects within one picture.

By four years of age a child:

1. Does not recognize or match several colors.
2. Does not understand how things are used (e.g. spoon for eating).
3. Does not use imitation or imagination in play.
4. Seems to "forget" how to do things (e.g. work a puzzle).

By five years of age a child:

1. Has a very short attention span.
2. Cannot answer "what if" questions.
3. Is unable to expand problem-solving skills.
4. Cannot point to and name 4 - 6 colors.
5. Cannot draw, name and describe recognizable pictures.

COGNITIVE DEVELOPMENT

Handout 5-C

Possible reasons for cognitive delays

A broad range of factors can contribute to delays in cognitive development. Some of these include

1. Premature birth
   Premature infants perform below those born at full-term, at least for the first few months, and this is to be expected. It will not necessarily continue.
2. Brain damage can result in cognitive delays ranging from mild to severe.
3. Problems in fine motor development may look like a cognitive delay but the fine motor delay is the primary concern.
4. A child with a hearing impairment may appear to be delayed cognitively where actually it is a problem of getting the information in the first place.
5. A home environment which does not have a variety of toys and opportunities to explore and experiment may cause a child to seem cognitively delayed.
6. Emotional problems can interfere with developing cognitive skills.
7. Children who are especially distractible for their age often have more difficulity learning certain skills because of their difficulity in concentrating on a task.

COGNITIVE DEVELOPMENT

Activity 5-D

Answer True or False to the following statements.

Be concerned if:	True	False
1. A three year old cannot respond to simple directions.	_____	_____
2. A one year old cannot name a couple parts of the body.	_____	_____
3. A two year old cannot answer "what if" questions.	_____	_____
4. A five year old has a very short attention span.	_____	_____
5. A one year old does not explore and handle a wide variety of objects.	_____	_____
6. A four year old does not use imitation or imagination in play.	_____	_____
7. A three old cannot draw, name and describe recognizable pictures.	_____	_____
8. A one year old does not match objects that go together.	_____	_____
9. A five year old is unable to expand problem-solving skills.	_____	_____
10. A two year old does not name or point to familiar objects on request.	_____	_____

(See answers on page 54.)

COGNITIVE DEVELOPMENT

Activity 5-E

Do one of the two experiments described below with a four or five year old and summarize what happened.

1. Take two glasses of water - same size, same amount. You and the child should agree that the amounts are the same. Take one glass and pour the water into a third glass - (either short and wide or tall and narrow but clearly different from the other glasses). Now ask the child if they are still the same or if one has more to drink. Now pour the water back to the first glass and again ask the child if they are the same or if one has more.

2. Take two balls of playdough - same color, same amount. Make sure you both agree they are the same. Take one of the balls and make it into a different shape. Ask the child if there is still the same amount or if one has more. Make the piece back into a ball and ask again whether the amounts are the same or if one has more.

COGNITIVE DEVELOPMENT

Activity 5-D Answer Sheet

1. True
2. False
3. False
4. True
5. True
6. True
7. False
8. False
9. True
10. True

PART VI MOTOR DEVELOPMENT

I. Handout 6A - Motor Development

II. Handout - Developmental Milestones 3A

III. Handout 6B - Motor Growth and Development

IV. Tape

V. Handout 6C - Suggested Motor Activities

VI. Handout 6D - Motor Development. Be concerned if.

VII. Activity 6E

VIII. Handout 6F - Seizures

MOTOR DEVELOPMENT

Definition of Terms

Fine Motor: Consists of the use of the hands and fingers in grasping and manipulating objects.

Gross Motor: Includes postural reactions, head balance, sitting, standing creeping, walking.

Areas of Sensory Input:

Tactile: Touch sensation.

Vestibular: This system has nerve endings in the inner ear that sense movement; lateral and rotational movement.

Proprioception: This system receives information from muscles, tendons, bones and joints. Most clearly illustrated through weight bearing positions; eg: wheelbarrow, crawling or pushing and pulling activities. Usually a subconscious sense which the nervous system interprets.

Kinesthesia: Conscious awareness of body position and movement.

Auditory: Sense of hearing.

Vision: Sense of sight.

Olfaction: Sense of smell.

Major Points to be Aware of in Working with Children

I. Quality of a child's movement is more important than their developmental level. Rigid? Fearful? Uncoordinated: ?

II. Children do not continue in a behavior unless they are getting something good or organizing out of it. We as adults have responsibility to recognize this and help them channel their needs appropriately.

III. Children are the best judge of what they need and when they have had enough. We need to respect this and respond to their efforts to communicate this to us.

MOTOR DEVELOPMENT

Handout 6A - continued

Important points to remember:

1. The quality of a child's movement is more important than the child's developmental level. Look at how children use their bodies as well as what they do.

2. Children do not continue in a motor activity or behavior unless they are getting something out of it. If it is inappropriate or hurtful to the child, it is the adult's responsibility to guide or redirect that movement appropriately.

3. Children are the best judges of what they need and when they have had enough. It is important to have activities in which children control the movement. Do not impose activities, such as spinning, on children.

4. Sometimes children who seem to have a behavioral problem are really experiencing some delay in motor development. When they receive appropriate help there is usually also a change in behavior.

MOTOR DEVELOPMENT

Handout 6B

Motor Growth & Development

MOTOR refers to the movements of the body and its parts. The development of coordinated motor movements is a little like the word game "SCRABBLE." In Scrabble, certain letters in one or several words are used to build a new word. So it is with motor development. Certain basic, preliminary skills must be present or mastered before other more advanced skills can properly or readily develop. A child must be able to control his arm movements, for example, before he can control his hand movements. And like the many words that become intertwined near the end of a Scrabble game--most motor skills involve the use and overlapping of many other skills: VISUAL, AUDITORY, SENSORY and MENTAL. For example, all of these skills are brought into play when a child is asked to cut a piece of paper in the shape of a square.

Smooth body movements require the coordinated use of many muscles. Four major areas of muscle or motor development are:

GROSS MOTOR

The use and development of LARGE MUSCLES--arms, legs, trunk of body, neck, etc. It usually involves large movements, perhaps coupled with power.

FINE MUSCLE

The SMALL MUSCLES of the body--hands, feet, eyes, eyelids, lips, tongue. Small movements that do not involve a large amount of power, but a considerable degree of careful control and coordination.

SENSORY MOTOR

The INTEGRATION OF BOTH GROSS AND FINE MOTOR SKILLS needed, such as those for maintaining balance, smooth body movements, the coordinated use of both sides of the body, discriminating by touch and feel, relating one's body to space and other objects as needed for judging distance, knowing up from down, right, left, etc.

VISUAL MOTOR COORDINATION

The HAND-EYE COORDINATION required for the hand (or fingers) to follow "directions" given by the eyes, such as dropping a clothespin in a bottle, drawing shapes, forming letters.

Importance of Motor Development

Many child development specialists claim that a CHILD'S SELF-CONCEPT (how he feels about himself) is directly related to his motor skill development. Good use of his body leads to good thoughts about himself. Also, a child who has awkward use of his body may shun physical activities involving other children and become socially awkward as well.

Lags or delays in motor development can also affect a CHILD'S SUCCESS IN SCHOOL. Quite obviously, a child's ability to coordinate his hand with his eyes affects his ability to write and form letters, numbers, and words. Less obviously, however, a child's ability to read seems to be related to his motor skill development. Although the reasons are not known, most children who have trouble reading also display poor motor coordination to some degree.

Key Patterns of Development

From the uncoordinated movements of early babyhood to the control necessary to pick up a pin---certain predictable patterns emerge:

* DEVELOPMENT OCCURS IN AN ORDERLY SEQUENCE. "You must walk before you run" aptly illustrates that there are certain steps a child must go through before he goes through others.

* A CHILD FIRST DEVELOPS CONTROL OF GROSS OR LARGE MUSCLES BEFORE HIS SMALL, FINE MUSCLES. For example, control of the arm comes before control of the hand; the hand before the fingers.

* MUSCLE CONTROL DEVELOPS FROM HEAD TO THE TOE. A baby can balance his head before lifting or turning it (which requires neck muscle control). A baby uses his arms to pull himself up, rather than his knees when first learning to stand. A child can accurately throw a ball before he can accurately kick it.

* CONTROL COMES FIRST TO THE CENTER OF THE BODY, THEN MOVES OUT TO THE LIMBS. A baby first turns himself by throwing the weight of his torso and shoulders, later by the use of his elbows and arms. A child can copy something easier, for example, when it is placed directly in front of him rather than to one side.

Stages of Motor Development

WHAT A CHILD CAN DO is affected both by his age and his stage of development.

A CHILD'S AGE can often serve as a guide because there is a general age range within which most children develop certain skills. Some "typical" motor type skills are listed in chart from on the following pages. Do not, however, interpret these too strictly. Every child has his own timetable.

A CHILD'S STATE OF DEVELOPMENT can be an even more accurate gauge. For this reason, note particularly that within each age range the skills are listed in the order or sequence you can expect them to develop. A child walks alone up stairs before he walks down; uses two feet to a tread before he alternates feet, etc.

RECOGNIZING "WHERE YOUR CHILD IS" IN HIS DEVELOPMENT CAN HELP YOU.....

* Know what to expect and what NOT to expect! A child who is still trying to gain control of his arms (as in catch or a bean bag throw) does not yet display sufficient hand and finger control for coloring within the lines. Expecting or unintentionally pushing a child to do things he is not ready for can cause him to have unnecessary feelings of frustration and failure.

* Provide appropriate activities and experiences to help stimulate his development. For example, if his age and actions indicate he is currently trying to develop arm control---provide experiences that will enhance it. Set up a box or large waste basket as a target for ball throwing, placed close, then gradually farther away.

* Determine if he is where he should be. Detecting a decided lag or delay can alert you to areas in which he needs extra help. If your child is unusually far away from the level offered here as an average, it may be a signal to keep special help or advice.

Encourage Motor Development by:

* ALLOWING MOTHER NATURE TO TAKE HER NORMAL INTENDED COURSE. She provides for the experiences a child needs in order to develop the necessary motor-visual skills. Babies like to crawl and climb and touch. Older preschoolers like to leap and climb the path Mother Nature intended her children to take. Too many "No's" and "Don't do that!" inhibit a child's natural tendency to move about and explore his enviroment. This hampers the development of his ability to learn how to control his enviroment and his own body. Free play and movement contribute greatly to good muscle control.

* INVOLVING CHILDREN IN TASKS IN AND AROUND THE HOUSE as soon as they show the slightest capability---raking leaves, emptying waste baskets, picking up paper and litter, sweeping, dusting, drying dishes, setting table, pouring water into glasses, etc.

* LETTING THEM DO FOR THEMSELVES as soon as they are able. Learning to buckle their own boots, their own shirts, pick up their own toys, put on their own wraps, cut their own meat, are excellent experiences in coordinating the hand with the eye.

* PROVIDING THE KIND OF TOYS AND EQUIPMENT THAT ENCOURAGE THE DEVELOPMENT AND USE OF LARGE MUSCLES---tricycles, balls, bats, frisbees, skate boards, ladders, hula hoops, jumping ropes and large boxes to climb in and out of and through.

* SUPPLYING ITEMS THAT ENCOURAGE THE DEVELOPMENT OF HAND AND EYE COORDINATION. Games that have targets---bean bag toss, ring toss, bows and arrows (rubber-tipped for safety), rubber horse shoes, child's croquet set, etc. Toys that can be manipulated---blocks, peg boards, sand boxes, etc. Art supplies for the sake of the process, not product---crayons, paints, paper, glue, scissors and clay.

* INCREASING YOUR OWN UNDERSTANDING OF JUST HOW MOTOR SKILLS DEVELOP. Carefully read the following page, "Patterns of Motor Development" and the accompanying folder, "Ages and Stages of Motor Development". These may provide some new insights as to how to best work with your child at his current level of development.

* FINE MOTOR (small muscle)
* SENSORY MOTOR (gross and fine motor coordination)
* FINE-VISUAL MOTOR (hand-eye coordination)

Material from:

Parent-Child Early Education Program
Ferguson - Florissant School District
Title III, Sec. 306, ESEA.

MOTOR DEVELOPMENT

SUGGESTED MOTOR ACTIVITIES

GROSS MOTOR ACTIVITIES

Obstacle Courses

Set up equipment (tires, carpets, large foam shapes, sturdy chairs, slides, climbers, etc.) which allows children to climb, jump, roll, bounce or swing.

Large truck inner tube

Children can straddle it, bounce, fall off - have a mat or carpet underneath to cushion.

Swings

Stimulate vestibular and proprioceptive senses.

Inflated air matress

Children can walk on it barefoot - different sensation, different way of balancing.

Scooter boards

Boards with coasters on each corner - may be carpeted on top. Children sit or lie on them and can spin themselves, push forward and back using their arms.

Sit-and-Spin

Children spin themselves around using both hands to make the Sit-and-Spin go.

Balls

Large beach balls are easier for young children to kick, catch or hit.

Bean Bags

Can be made in different shapes and sizes, from different textures. Children can throw them at a target, into a tire, through a hoop, etc.

Starting and stopping games

Starting and stopping one's body can be activities in themselves. "When I say go, everybody run When I say stop, Touch the grass"

Parachute Activities

A small, eight foot parachute was purchased at a local army surplus store.

1. With the class holding onto the edges of the parachute, everyone takes a step or two backwards to make a circle; walk around the circle (continue holding onto the parachute), stop, change directions.

2. holding onto the edge, jump, run, hop, skip around the circle; incorporate stop and go concepts; change directions.

3. use the Hap Palmer Record song, "Walk Around the Circle," and do the various movements to music.

4. with the class holding onto the edges of the parachute, roll the edge inward, step backward to make the material taunt and make waves by moving arms up overhead and down to knees.

5. taking turns, one child at a time walks in the waves being made by others.

6. holding onto the edge, roll the edge inward, count out loud to a given number, such as three or five and say, "up," while lifting arms overhead; allow parachute to float down.

7. after the counting and "up" concepts are understood, play a game where one child at a time is chosen to run under the parachute as the others move their arms upward.

8. chose one child at a time to become a flower; this child stands in the middle of the parachute while the other children slowly walk around him/her while holding onto the parachute edge; the parachute wraps around the child in the middle and excess material is placed on that child's shoulders; the child then must jump up and down to disengage himself/herself and "bloom."

FINE MOTOR ACTIVITIES

1. Spraying water with spray bottles on body parts and having the child rub dry with various textured materials, such as terry cloth, sponges, cotton, paper towles.

2. Make a "tactile" (feel) board" to have in the classroom. Provide tagboard, paste, and a variety of textures (fake fur, sponge, carpet, foam, sandpaper, nylon, cotton, scouring pad, etc.) to touch on face and arms and hands before pasting them on the tagboard.

3. Taste opposites; sweet/sour, sweet/bitter, salty/nonsalty; textures too; crunchy/soft, liquid/solid, smooth/rough.

Fine Motor Activities (Continued)

4. Make a "smell board" to have in the classroom. Provide tagboard, paste, cotton balls, eye droppers, and a variety of smells, such as lemon juice, rubbing alcohol, vanilla, vinegar, perfurm, tabasco sauce, etc. After smelling all these, give each child cotton balls, eye droppers, and the smells so that some of the liquid can be placed on the cotton balls with the eye droppers before pasting them on the tagboard.

5. Make peanut butter play-dough with your hands by combining 1/4 cup of honey, 1/4 cup of peanut butter, and 1/2 cup of dry milk.

6. Mix together in a bowl 1/2 cup white glue and 1 cup liquid starch to make silly putty. This is a good texture to handle.

7. Tearing newspapers into strips, then into small pieces to make "snow." Then throw it up into the air to make a "snowstorm." Place in large cardboard box and take turns tramping (jumping) down.

8. Place a colander upside down on a flat surface. Have the children put colored toothpicks through the holes. The toothpicks disappear! Toothpicks can be sorted by sameness or specific color.

9. With cylinders from bathroom tissue rolls and halved paper towel rolls, noisemakers can be made. Staple one end of the cylinder shut. Have children put cereal or dry beans into the cylinder using a three point grasp. Then have the children help you staple the end shut by pressing down on the stapler. To complete the noisemaker, the children can decorate by painting, coloring with markers, or brushing on liquid starch (which is a good glue) and sprinkling on glitter.

10. Make a collage using tongs and/or tweezers to place various objects (cotton balls, pieces of material, buttone, dry cereal, macaroni, pieces of styrofoam, scraps of leather, string, yarn, pipe cleaners) on a piece of paper that has been spread with paste using fingers.

SENSORY-MOTOR ACTIVITIES

1. Rolling - have each child roll across a designated area. Have children try to keep head, shoulders and hips on the floor.

2. Be a snake - creep on tummy across designated area and back.

3. Puppy Dog Run - run forward on your hands and feet.

4. Sit on floor, stretch arms out to sides, make circles with arms--small, big, fast, slow, reverse directions.

5. Form a ball - lie on backs, form a ball with hands encircling knees. Repeat.

6. Airplane - on tummies, have arms outstretched to sides, raise chests, head, and legs off floor, arching back.

Sensori-Motor Activities (Continued)

7. Crawl forward, backward, and sideways along a tape line.

8. Sitting on floor with legs bent and held up toward chest. Child uses hands to spin around. Once moving, have child raise hands and balance on his/her seat. Spin clockwise and counter clockwise.

9. Hot potato - sitting, pass ball from one person to the next around a circle. Pass ball overhead, behind backs, and in front.

10. Crawl pushing a ball or beanbag with heads across the room.

11. Play musical chairs with chairs of different heights.

12. Walk through an obstacle course stepping up, down, into and out of things.

Reference: Sensori-Motor Activity Guide for Preschoolers from Birth to Age 5, Diane Devereaux Bicanich, Carole Wick Manke.

MOTOR DEVELOPMENT

Handout 6D

MOTOR DEVELOPMENT: Be Concerned If . . . . . .

Be concerned if you answer yes to any of the following questions about a child's motor development.

Does the Child:

	yes	no
1. Object to being touched, especially light touch. For example, does the child pull away when you put your hand on his back, or an arm around his shoulders?		
2. Dislike being held or cuddled.		
3. Seem clumsy or uncoordinated: often bump into things, fall down, fall of a chair, lose balance.		
4. Seem to have unusually stiff, rigid or tense muscles.		
5. Seem to have unusually loose, limp, or floppy or weak muscles.		
6. Seem listless, less active than other children, or appear to space out.		
7. Seem restless, easily distracted, inattentive, motoric, need to move around more than other children do, or persist in repeating a specific movement.		
8. Have poor attention span for his/her age.		
9. Have difficulity manipulating small objects smoothly and with a purpose.		
10. Fear losing his/her position in space or fear losing his/her balance. For example, does child seem apprehensive about twirling around, being tipped to one side, standing on one foot or jumping.		
11. Tend to ignore using one side of his body, disregard one hand in activities; Does the child tend to respond to objects faster when put near his/her left or right? Does the child look more at one side of a book or paper?		
12. Switch hands for activities or does child show an established preference for one hand.		
13. Show an overall awkwardness when moving. For example does he/she move smoothly or awkwardly; does the child walk with a gait, does the child walk more on his toes than on his/her feet.		
14. Motor skills seem to be developing slower than skills in other areas (problem solving, speaking, and social/emotional).		
15. Seek out firm touch, such as throwing himself into things.		
16. Frequently interrupt or frequently talk while others are talking?		

MOTOR DEVELOPMENT

Handout 6D - continued

	yes	no
17. Seem to be very disrupted by noise?		
18. Not get dizzy after spinning.		
19. Seem to know how to do something one day and the next day cannot?		

MOTOR DEVELOPMENT

Activity 6E

Choose two activities from Handout 6C and do them with your group of children. The activities you choose should be from different categories, for example, one from fine motor and one from sensori-motor.

List the senses and skills that were needed, and that the children used in completing the activities.

Motor Seizures

1. Motor seizure may be indicated by:
   a. A muscle jerk.
   b. Blinking
   c. Rapid fluttering of the eyes.
   d. A child who sits down at the table and promptly falls off chair - seems fine afterward.
   e. A child who is drawing and suddenly scribbles over the paper but is unaware of having done it.
   f. A child who is generally skilled in motor activities, but begins falling alot, seemingly over nothing.
2. Children may or may not seem confused following a seizure.
3. Report to parents any behavior which may be indicating a seizure.
4. Keep track of these behaviors and include the following information:
   - how often these behaviors occur
   - how long they last
   - what time of day they occur
   - what the behavior is (falling, staring, etc.)
   - how the child behaves afterward
5. Do not spin a child who has a diagnosed or suspected seizure disorder as it is possible to bring on a seizure.
6. Medication
   a. A variety of medications are used to control seizure activity.
   b. Children and the seizure activity are affected differently by various medications.
   c. When first starting a medication children may seem sleepy, less active or less alert. This should not continue when the medication has settled at the proper level.
   d. Report to parents any seizure activity you see.

AGE	1½ - 2 years	2 - 2½ years	2½ - 3 years
GROSS MOTOR	Picks up toy from floor without falling. Pushes and pulls large toys, boxes, etc. around floor. Climbs forward into adult chair, then turns around and sits. Uses while arm movements in painting. Throws ball overhand. Kicks ball forward. Walks upstairs unassisted. Walks downstairs when one hand is held. Stands on left foot alone. Pedals tricycle. Walks on line, general direction.	Runs safely on while foot, stopping and starting with ease and avoiding obstacles. Squats to play with object on ground and rises to feet without using hands. Pulls wheeled toy by cord. Can climb on furniture and can get down again. Bends at waist to pick something up from floor. Can kick a ball. Jumps from bottom step. Walks upstairs alone; both feet on each step. Walks on tiptoe, few steps. Walks downstairs alone; both feet on each step.	Walks upstairs alone, but downstairs holding rail, two feet to a step. Jumps with two feet together. Can stand on tiptoe if shown. Jumps over string 2-8 inches high. Hops on one foot, 2 or more hops
FINE MOTOR	Picks up small beads, threads, etc. immediately on sight with delicate pincer grasp Turns pages of book, 2 or 3 pages at a time. Begins to show hand preference Watches and retrieves 2-1/2 inch rolling ball up to 10 feet. Shifts brush from one hand to another in painting. Makes spontaneous scribble when given pencil and paper, using preferred hand. Imitates vertical line. Closes oblong box. Can build tower of 5 blocks. Can imitate a circular scribble, when he has seen it demonstrated.	Picks up pins, etc. quickly. Makes spontaneous circular scribbles and dots when given paper and pencil. Turns page singly. Has well-developed handedness. Turns door handles. Likes to take things apart and put together again. Can roll, pound, squeeze, and pull clay. When painting, "scrubs" paper. Fills pots and dishes with sand, dumps, throws. Highly interested in water play. Prefers action toys (trains, cars, telephone) Imitates - and l lines Manipulates egg beater (1 of 3 trials boy or girl) Understands 2 prepositions of following: on, in, under, behind, in front of, etc.	Enjoys marked rhythm of band music. Will usually run, swing to music, watching others. Experiments with vertical and horizontal lines, dots and circular movements. May go out of bounds, painting on table, easel, floor, own hands, other children. Makes pies and cakes with sand and mud, patting and smoothing them. Lines blocks to form "train". Holds crayon with fingers. Draws 2 or more strokes for cross. Can carry breakable objects. When seeing long lines, can select the longer line, 3 out of 3 times.

*The skills at the top of the list will tend to develop reasonably early in the given age range; the skills nearer the bottom, during the latter part of the age range.

AGE	3 - 4 years	4 - 5 years	5 - 6 years
GROSS MOTOR	Turns wide corners on tricycle. Can swing. Squats to play on floor. Can walk heel-to-toe. Catches bounced ball. Can hop on one foot.	Turns sharp corners, running, pushing, pulling. Climbs ladders and trees. Skips on one foot. Skips to music. Balances on walking board. Hops on one foot. Balances on one foot for 10 seconds.	Skips on alternate feet. Can jump rope. Can run with few falls, playing games at the same time. Is able to sit longer. Learns to use overhead ladder. Can roller skate.
FINE MOTOR	Picks up pins, threads, etc. with each eye separately covered. Can close fist and wiggle thumb in imitation, right and left. Draws head of man and usually one other part. Paints pictures with large brush on easel. Drives nails and pegs. Holds crayon with fingers, rather than fist. Prints a few capital letters -- large, single letters placed anywhere on page. Cuts with scissors.	Imitates spreading of hand and bringing thumb together with each finger, each hand. Draws man with 2 - 3 parts. Draws very simple house. Prints a few capitals, usually the initial capital of his first name. Prints simple words (from demonstration). Folds and creases paper 3 times (from demonstration). Copies cross. Copies square. Draws man with 6 parts (58 months).	Draws a triangle. Writes a few letters spontaneously. Draws recognizable man with head, trunk, legs, arms and features. Draws simple house with door, windows, roof, chimney. Counts fingers on one hand with index finger of other. Frequently reverses letters, especially s and d. Prints numbers 1-5, uneven and medium sized. Can trace around a diamond drawn on paper. Can tie a single knot around a pencil with a shoelace after looking at a model. Catches a ball 5" in diameter from 6 feet. Learns to lace shoes. Buttons 2 buttons on a 2-button strip in 19 seconds.

PART VII - Social and Emotional

I. Tape

II. Activity 7A - True and False

III. Tape

IV. Handout 7B - Signs of High Risk in the Preschool Child

V. Tape

VI. Handout 7C - Descriptions of "Teacher Techniques"

VII. Handout 7D - Catch 'Em Being Good

VIII. Activity 7E

Activity 7A

Social and Emotional Development

Mark T(True) or F(False)

	True	False
1. Dealing with children who have delays in this area can be tricky because one's own emotions are also involved.		
2. People generally agree on what is acceptable or not acceptable behavior.		
3. Emotional development follows a sequence.		
4. Children experience and express a wide range of emotions.		
5. Children's fears can be related to their developmental level.		
6. Providers can do little to help diminish children's fears.		
7. Regression is one way a child may express jealousy.		
8. Children express anxiety in only one way.		

7A
Answer Sheet

Social and Emotional Development

1. True
2. False
3. True
4. True
5. True
6. False
7. True
8. False

SOCIAL AND EMOTIONAL DEVELOPMENT

WASHBURN CHILD GUIDANCE CENTER
SIGNS OF HIGH RISK IN THE PRESCHOOL CHILD

I. Behavioral Signs

It must be kept in mind that the meaning of all behavior is relative to the age and environmental situation of the child who manifests it. There are vertually no behaviors, particularly behaviors of preschool age children, which always can be considered to be indictive of problems. What is a "problem" or maladaptive behavior at one age may be adaptive or even typical at another age. A behavior which one parent or teacher finds intolerable and therefore a "problem" may be highly valued behavior for another parent to teacher. However, there are some behaviors which, if they persist to school age, are likely to lead to social ostracism, to interfere with academic performance or in other ways to create problems for the child in a majority of academic and social settings in our culture as it exists at present. These behaviors, enumerated below, are the ones which at the least warrant careful observation over a period of time and in cases where they persist more than six months or are unusually severe they should be evaluated by professionals in the child behavior field.

A. Problems in interacting with the environment: in alertness or receptiveness to environmental stimuli, in activity level or acting upon and responding to stimuli in the environment.

1. The infant who does not turn to sound, does not look at bright or moving objects, does not "track" visual stimuli, or reach for an object near his grasp.
2. The infant who overresponds to any external stimulus such as noise, touch or light, startles easily, cries, covers ears or eyes.
3. The infant or toddler who is a "good" baby, remaining silently where placed, never climbing out of crib, never getting into things, generally showing a lack of exploratory behavior.
4. The overly active toddler or child who is constantly and inappropriately engaged in physical activity, who is into everything, on everything, breaking everything, showing no restraint or ability to respond cognitively to his environment.
5. The child who destroys his environment or aggressively acts upon things, breaking toys, throwing things, tearing, cutting, burning, or otherwise inappropriately defacing property. This type of destructiveness needs to be distinguished from normal amount of breaking which may happen in the course of exploratory play.
6. The child who cannot attend to a stimulus or an activity for an age-appropriate period of time, but constantly "spins" about from one thing to the next without getting involved in anything.

B. Problems in interacting with other people; in responding with appropriate affect to other people, in communication, in assertiveness, in modeling the behavior of parents.

1. The infant who by about 16 weeks does not smile, gurgle, or otherwise show pleasure when approached, or cuddled.
2. The infant of 40 weeks to 1 year who typically does not cry when mother leaves or has been out of the waking infant's sight for a period of time.
3. The child who at around one year of age does not yet seem to differentiate between strange and familiar persons, e.g., shows no fear of strangers such as doctors and nurses or no particular recognition of his mother. In effect he doesn't seem to care whom he is with.
4. The infant who does not begin using verbal output to communicate and control to some extent by one year.
5. The child who does not begin to make a transition from physical relationship with others to verbal by age 4, who relates by hitting, pulling, biting, etc.
6. The child who is excessively dependent upon parents, can spend no time alone, whines, clings, cries excessively upon separation. For example, clings to mother rather than exploring toys or materials or interacting with other children.
7. The child who shows no interest in parents' or other persons' comings and goings, occupying himself in solitary pursuits.
8. The child who shows no interest in other children either positive or negative.
9. The child who uses temper outbursts or negativism to control others beyond the age of three or in excessive degree.
10. The child who at age 3-1/2 or 4 cannot share or wait his turn.
11. The child of 4 or older who cannot involve himself in group activities or interactive games with other children. He may be oblivious or stand on the sidelines and resist attempts to involve him.

C. Problems with the self.

1. The infant or child who is totally engrossed in himself, engaging in self stimulating behavior as a major activity.
2. The child who repeatedly harms himself physically, biting himself, pinching, banging head, etc.
3. The child who generally appears sad, crying or the child who shows unusual flat affect --shows no appropriate signs of pleasure, sadness, fear or anger, etc.

C. Problems with the self. (continued)

4. The child who lacks confidence in self, frequently says "I can't" or otherwise criticizes self.

5. The unusually anxious or fearful child whose fears interfere with normal activity. Examples would be excessive fear of strangers, new situations, water, physical activity, etc.

II. Developmental Signs

It is important to be aware and to help parents be aware of general developmental milestones for training (eating, sleeping, eliminating and other self-care behavior), motor and language development in infancy. Any child who is found to be lagging by even four to six months in any area should be followed carefully. Help should be given the parent in providing extra stimulation or special management. If the lag continues to be apparant six months later, even if some progress has occured, the child's development should be evaluated using a systematic screening instrument or he should be referred for diagnostic evaluation.

By the time a child is two years of age (in some cases even before), it is possible to pick up more specific lags in development of a type which, in the elementary school years, are related to academic learning disabilities. Among the more significant developmental signs of high risk for SLBP are the following:

A. Problems in gross motor development or in using large muscles of the body, particularly in arms and legs, smoothly and in balanced coordinated fashion.

1. The child who is unusually slow in walking - later than eighteen months.

2. The clumsy child who frequently stumbles, falls, bumps into things.

3. The child who avoids motor activities such as riding kiddie cars or tricycles, games which involve throwing, jumping or hopping, or perhaps even running.

4. The child who cannot do the things noted in (3) above even though he tries.

B. Problems in fine motor or visual-motor development, in using small muscles, particularly in hands in careful, controlled movement, and coordinating eyes and hands, so the child can act accurately upon what he sees.

1. The child over two years old who is always spilling his milk (accidently) or dropping things or is slow to learn to eat with a spoon and fork (over three years old) or cannot remove any of his own clothing.

B. Problems in fine motor or visual-motor development (continued)

2. The child over three or four years old who shows no interest in using crayons, pencils, scissors, etc.
3. The child who cannot use the materials listed in (2) above or cannot independently put together simple preschool puzzles, or build with blocks.
4. The child of 2-1/2 or 3 who cannot make at least circular, verticle and horizontal marks with a pencil and the child of 4 or 5 who cannot draw an at least vaguely recognizable "person".

C. Problems in visual preception, sequencing and memory or the ability to "see" correctly and remember in the correct orientation and order what is seen.

1. The child over 3 years or so who continually tries to force puzzle pieces into the wrong spaces in a puzzle.
2. The child who cannot match identical objects by colors, shapes, sizes, or other simple similarities which are identified for him.
3. The child who repeatedly puts on his or doll's outer garments before under garments or shoes before socks even with repeated demonstrations of the correct sequence.
4. The child who cannot remember where a toy or article of clothing is, even though it is alwasy kept in a certain place, or who frequently mistakes sib's or peer's clothing or possessions for his.

D. Problems in auditory perception, sequencing and memory, or the ability or "hear" accurately and remember in correct order what is heard.

1. The child who continually mispronounces words or incorrectly sequences the sounds in words (e.g., pasketti for spaghetti).
2. The child who appears to hear but frequently says "huh?" or "what?" or looks blank when spoken to.
3. The child over eighteen months who cannot follow simple verbal instructions correctly, who may forget enroute even simple directions such as "bring me the newspaper" or may follow instrutions in the wrong order or incompletely.
4. The child who cannot correctly repeat a verbal comment or sentence immediately after it is given.
5. The child who does not readily pick up TV commercials, songs, nursery rhymes, etc.
6. The child who cannot remember any part of a story after it is read to him.

E. Problems in receptive language or the ability to derive meaning from the verbal communications of others

1. The child who has an adequate vocabulary for age but frequently responds to questions with inappropriate answers - who doesn't seem to "get the message."
2. The child who seems to misunderstand a story being read to him or a TV program.
3. The child who shows no interest in listening to stories.

F. Problems in expressive language, the ability to form words, to thoughts or ideas into words, and to put words together correctly to convey meaning to others.

1. The child of age 3 or over who does not talk.
2. The child with speech articulation problems (relative to age).
3. The child who remains "physical" in controlling his social environment beyond age 2 1/2 or 3.
4. The child with a limited vocabulary or inability to develop correct syntax.
5. The child who cannot put his feelings into words - can't say that he likes or dislikes, is happy or sad or angry, or what is that may have aroused the feelings.
6. The child who cannot describe an experience or a picture or ar object.

G. Problems in cognitive development, or the ability to make comparisons, see relationships, generalize, differentiate, and otherwise make correct associations between stimuli and ideas.

1. The child who uses labels indiscreiminately (e.g., calling all small animals "dog" because he has a dog), or incorrectly (calling boys girls, etc).
2. The child who is slow to develop even basic concepts such as up and down, big and little.
3. The child who, by the age of 2 1/2 can't give his own name, can't identify his body parts on request, can't tell if he is a boy or girl.

G. Problems in cognitive development, or the ability to make comparisons, see relationships, generalize, differenciate, and otherwise make correct associations between stimuli and ideas. (continued)

4. The child who cannot solve even rudimentary problems others his age can - the young child (1 1/2 to 2) who cannot dump a desired object out of a bottle or box or avoid closing door on fingers or go around a barrier to get something, or the somewhat older child who repeatedly tries to put too large things in too small containers, does not get a chair or box to reach desired object, cannot see that a shoe must be untied before it is put on, or repeatedly tries to pull his trousers over shoes.

5. The child of 4 or 5 who is not beginning to identify colors, to compare objects and identify same or different, and grasp the "symbol" concept in writing and reading.

6. The child of 4 or 5 who isn't developing some rote knowledge of alphabet, numbers, stories, nursery rhymes, etc.

SOCIAL AND EMOTIONAL DEVELOPMENT

DESCRIPTIONS OF "TEACHER TECHNIQUES"

Classroom Structure and Rules

Structure

Classroom Structure refers to teachers' expectations of children in the classroom. Classroom Structure includes the daily schedule of activities, the established order and routines, and the physical arrangement of the classroom. Meaningful structure can provide security for children. It allows them to develop a sense of trust by providing information on what is going to happen, what will be expected of them, and what they can, therefore, depend on. Changing children's physical environment when the activity changes can also add variety and predicability to the day.

Classroom Structure can help provide children with opportunities for successful experiences, especially by providing some external organization for children who are still in the process of organizing themselves internally.

Rules

There are several types of rules which children are expected to follow, including building rules, specific classroom rules, and interpersonal rules. It is most important that the rules which are imposed reflect the developmental level of the children, as well as their individual needs.

Body Contact and Touch

This technique refers to physical closeness or proximity to children and varies from touching children on the shoulder to hugging or holding them on a lap. Body Contact and Touch should be encouraging, positive, and consistent and is used to nurture, calm and reinforce children for their efforts.

The type and amount of physical contact will vary according to the needs of each child. Infant and toddlers want and need a good deal of body contact; i.e., sitting on laps, hugs, arm around shoulders. Older children move from a basic need for body contact to wanting some "ok" touching; i.e., pat on the back or sitting near the teacher. One must be aware, however, of children who may react negatively to physical contact and who truly cannot tolerate it. It is also important to remember to place oneself at eye level with children when physically near, being careful not to overwhelm them.

Control of Materials By Teacher

This technique refers to the extent to which the teacher takes responsibility for controlling the objects, pictures, foods, etc., involved in an activity with young chidren whose inner controls have not yet been completely established. For infant and toddlers, the teacher's role is one of almost total control, while still allowing for children's free exploration of materials during certain periods. Older children are given more control. For instance, older children might pour their own juice, while younger children would be given juice already in a cup.

Physical Intervention

Physical Intervention is a technique which refers to physically moving children through an activity by moving their hands, arms or bodies to help them successfully perform a task. Sometimes physical intervention is necessary to physically control children's movements, preventing them from doing harm to themselves or others or hold them within the group. In this way, the expected, appropriate, response can be emphasized and taught.

Physical Intervention is done in a caring and supportive manner and is often accompanied by specific words or a simple phrase that is related to what is happening at present.

Redirection

The teacher using Redirection guides children back into an on-going activity or helps them join one just beginning. It is used to help children refocus their attention or to avoid confrontation by intervening in a positive manner.

Verbal Interaction Between Teachers

This technique involves a verbal exchange between members of the teaching team; a dialoguing between staff members that is so commonplace in preschool classrooms.

This technique can provide verbal and behavioral models for children to imitate, help cue children into the next activity, stimulate interest in the task at hand, or communicate information about an event occurring to about to take place. It can often help neutralize a potentially explosive situation by avoiding direct confrontation with a child(ren). Confrontation is developmentally a much higher skill for children and adults! A specific verbal exchange between two teachers about clear options available to all children in the class can provide the child(ren) the opportunity to comply/cooperate appropriately. Verbal Interaction is often used in conjunction with Redirection.

Reflection

When reflecting, teachers label children's experiences and actions verbally, discussing what the children have said, done, or may be feeling. Often teachers interpret what has just occurred, giving children the words that they do not have and providing verbal models for putting their experiences into words.

Reflection requires no response from children although a conversation will often take place. It helps children be aware that their teacher notices what they are doing, without necessarily making any judgements on their behavior or making any immediate further demands. Reflection is often a way to reinforce children for their successes or to indicate how they may be successful in the future. It may be used to help encourage cooperative interaction among children.

Removal From The Group

This technique allows children to be separated from the group in which they have behaved inappropriately, yet still remain in the classroom. Here it is possible for them to continue to observe and hear the group activity and soon be motivated to re-enter the group and participate appropriately. The specific goal of Removal From the Group is to have the child be motivated to return to the group by noticing/observing the fun, interesting, exciting activity he/she is missing. In addition, teachers can talk to children about their actions, explain the consequences of them, and then describe the behavior that the children must demonstrate in order to return to the group. (e.g., "When I see you have stopped kicking, I'll know that you are ready to join us.")

Reference: "Developmental Therapy", Mary M. Wood.

CURE FOR PROBLEM KIDS:

Catch 'Em Being Good

by Ray McGee

No matter what your occupation, if you're a parent, your work's cut out for you. Like most, you probably find parenting not only the most difficult job you face but one for which you are least prepared.

"The key to developing desirable behavior is to build on a child's inherent strengths," states Ray McGee. He's been helping parents and their offspring solve child learning and behavioral problems for almost 20 years. During that time he's worked with children and adolescents through court and family service agencies, in psychiatric hospitals, and as a high school teacher. Since 1969 he's been affiliated with Washburn Child Guidance Center, Minneapolis, Minn.

McGee has developed a common-sense, creative approach to raising children. As he puts it, success in this all-important endeavor depends upon "Who do we catch children being?...Who do we tell them they are?"

You can catch kids being right and you can catch kids being wrong. You can catch them being weak, you can catch them being strong. You can catch them displaying almost any type of behavior - both desirable and undesirable. The point is: what you catch them being determines what you tell them they are. And what you tell them they are, they almost invariable will be.

As a parent, your job is to develop your child's behavior based on positive strengths.

A Student In Turmoil

Many well-meaning, but mistaken, parents believe they have a solemn duty to single out their children's "bad" or "disruptive" behavior. However, emphasizing faults and poor behavior tends to produce the very results parents so much want to prevent.

Take Al, for instance. He began life with the odds all stacked in his favor. He was an "I'll take one of those" kind of babies, and entered kindergarten as a "good kid." In first grade, though, Al had slipped to a "kinda good kid." During second grade, Al was beginning to be known as a "bad kid."

At that time he still hadn't learned to read or write. So, he was placed in an advanced, high-priced tutoring program and responded by making two months' progress in four months. Although he learned more about reading and writing in those two months than he had in the previous years of school, it failed to satisfy school officials. Al was dropped from the tutoring program and labeled as "dumb."

Al continued to be promoted with his classmates. By fourth grade, students would provoke Al's ire by calling him "D.A." (short for Dumb Al). Such taunts angered him.

He responded with temper tantrums which earned Al repeated trips to the principal's office. There he was continually reminded of his inability to control his temper. Al devoted the next several years to developing the one talent everyone told him he was good at - throwing terrible tantrums.

By the time Al was brought to me at the age of 14, his disruptive behavior had progressed to the point where school officials, teachers psychologists and social service all agreed: "Al was no longer fit to attend school." Furthermore they warned, Al might even be "crazy."

"Al was dropped from the tutoring program and labeled as dumb."

Contrary to prevailing belief, however, Al had learned well the lessons taught in school: He "knew" he was "dumb", he "knew" he could not control his temper. He "knew" he was "crazy." Al was simply reacting to information others has been giving him for years. He had been "caught" displaying these forms of behavior. He was being "who" others had told him he was.

During our early sessions together I "discovered" Al's strengths. I learned he had a number of highly-honed talents - he was an expert water skier, an excellent snow skier and he could build model cars and airplanes with a true craftsman's painstaking care.

We spent considerable time emphasizing and concentrating on these and other desirable traits. It was my task to convince Al that he did, indeed, possess these traits and that he was a worthwhile person. Gradually his self-image and his behavior changed. His public displays of rage and anger ceased and, recently, Al graduated from high school with his original classmates.

A Positive Image

The key to such a change in behavior is simple. It will work with any child and is based on the positive self-concept embodied in the three words - "I like myself."

It's a difficult, even frightening statement for most of us to accept. But, it signifies that you have something (not everything, mind you), but something you can feel good about.

And that's important, Because if you feel good, you'll act accordingly. It's the same with kids. They need something to feel good about, something that you tell them they can and, hopefully, will feel good about. Something that both of you can use to motivate and to mold behavior in a desirable fashion.

Play Your "Cards" Carefully

In many ways the brain is similar to a computer. It's continually receiving, analyzing and acting upon information. Like a computer, a brain responds to "sound" inputs of data with "sound" results. Feed the brain "garbage" and, like a computer, results that "print out" will be of a comparable quality.

There, however, the similarity ends. For we give experts the computer. The rest of us get the kids.

Like a computer, you "feed" your child "cards" indicating expected behavior. You can offer "good" cards: "You're competent." "Your're intelligent." "You're courageous." Or, as happened with Al, you can provide "bad" cards: "You're dumb." "You can't control your temper." "You're crazy."

To achieve desirable behavior from our children we must practice the sophisticated, subtle art of noticing. Recognize our children's native abilities. Get "inside" their minds. Find and reinforce their strong points upon which to build good behavior.

For example, assume your 12-year-old son, against his own better judgment, decided to join his friends, skipped school for a day and got caught.

You can berate him for "doing such a dumb thing." Chances are, though, you'll be much more effective in preventing future stunts by making him first feel good about himself.

Try this approach: "You really are intelligent. But I can't for the life of me figure out how you got yourself in such a jam."

Plug in "Good" Cards!

Provide your child "good" cards. Whether you use gushing phrases of compliments, a gentle pat on the shoulder or a silent meeting of the eyes your goal is the same - to recognize and reward strengths.

Instilling desirable behavior in children is a difficult, awesome task. First step is to tell and convince yourself that, yes, you are a good parent. Next, identify strengths in your children's behavior. Convince them they have these strengths. Then repeat...repeat...repeat, and reinforce their good behavior

C-5014 Bobcat Worksaver Vol 2, No. 7; Webb Co., Box 3538, St. Paul, Minn. 55165
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7E

Social and Emotional Development

Read the following three episodes and list which techniques you might use to deal with the situations and why you would use those techniques.

I. When a child's parent leaves after bringing him to the day care, the child cries, won't hang up his jacket and is unable to choose a toy or activity to play with. What do you do?

II. At group time a child cannot sit for music and stories. She pokes and teases other children and cannot stay in one place. What do you do?

III. One child watches two others building blocks. When the two have completed their project the first child comes over and kicks it down. What do you do?

Or

Relate two episodes from your own experience, what techniques you used, and why; what others might you have used?

PART VII - Low Incidence Handicaps

I. Tape

II. Handout 8A - Low Incidence Handicaps

III. Handout 8B - Signs of Possible Problems

LOW-INCIDENCE HANDICAPS

Low-incidence handicaps are conditions which can often be diagnosed medically. Their causes are often more easily definable then those of a developmental delay alone.

I. CEREBRAL PALSY

A name given to a number of conditions (mild to severe) which injury to the brain affects the control of movements. The severity of the handicap depends upon how much damage has occured in the brain and which muscles the damaged part of the brain controls. There is no cure for Cerebral Palsy.

A. Causes

1. Prenatal

   a) blood imcompatability
   b) measles
   c) toxemia
   d) anemia
   e) low birth weight

2. Prenatal (during the birth process)

   a) lack of oxygen
   b) stressful birth
   c) brain hemorrhage
   d) brain injuries

3. Post

   a) diseases: encephalitis, moningtis
   b) head injuries
   c) lead poisoning

B. Treatment

Typically requires close monitoring by health care team and family involvement in home treatment; physical and occupational therapy, speech and language therapy; may need adaptive equipment for walking, eating, etc.

C. Associated Special Needs

May have epilepsy, hearing problems, visual problems, speech problems, (articulation and language delays). Sometimes mental retardation is also associated. However, many children with Cerebral Palsy have normal intelligence.

II. CLEFT PALATE (occurs in approximately one in 750 births)

A condition present a birth in which the roof of the mouth (palate) has a narrow opening (cleft) The hard palate, soft palate, lip, and uvula ("adam's apple") may be affected solely or in combination with others.

II. CLEFT PALATE (Continued)

A. Causes

Failure during the second and third months of pregnancy of the bone and tissue of the palates to fuse together. Suggested causes include malnutrition of the mother and lack of oxygen supply.

B. Treatment

The condition can be improved through a series of surgical procedures (skin graftings, physical and cosmetic surgery). Depending upon the degree of success of the surgery and other related factors, some children may acquire normal speech, while others may continue to sound hypernasal (air coming out of the nose while speaking), or denasal (as though has a cold or sinus condition). Speech therapy is important in helping to improve the problems associated with Cleft Palate.

C. Associated Special Needs

1. Speech and language delays (receptive and expressive)
2. Articulation delays: sounds which are especially difficult to prodounce include s,z,sh,ch,k, and g.;
3. ear infections
4. dental irregularities

III. VISUALLY IMPAIRED

Visual impairment can be classified into two categories: blind (one whose vision is so poor that s/he cannot be educated through visual methods) and partially sighted (can use visual cues to learn, but may need some extra adaptations)?

A. Causes

1. genetic factors
2. infections
3. accidents
4. tumors
5. excessive oxygen in incubators

B. Treatment/Intervention

1. medical correction
2. optical aids (glasses, etc.)
3. auditory and tacticle methods (braille, etc.)

C. Associated Special Needs

1. Possible problems with mobility and motor coordination
2. Social/emotional delays
3. Possible other developmental delays

IV. HEARING IMPAIRED

Hearing impairments can be listed in three categories: 1) conductive loss - caused by some type of blockage or malfunction in the outer or middle ear (Chronic ear infections can cause a conductive loss); 2) Sensorineural - caused by damage within the inner ear or damage to the auditory nerve leading from the inner ear to the brain; 3) Mixed loss - neither conductive or sensorineural systems work normally.

A. Causes

1. Prenatal

a) genetic
b) infections and diseases (eg., measles)
c) toxic agents
d) birth trauma
e) blood incompatability

2. Postnatal

a) childhood diseases and infections (meningitis)
b) head injuries
c) cerebral hemorrahage
d) tumors
e) prolonged exposure to loud sounds
f) toxic side effects of drugs

B. Treatment/Intervention

1. Conductive losses

a) medication
b) PE tubes to drain fluid in ears
c) surgery
d) speech/language therapy

2. Sensorineural

a) hearing aids
b) speech/language therapy
c) sign language (for the deaf)

C. Associated Special Needs

1. Receptive and expressive language delays
2. Articulation delays
3. Voice quality, inflection, pitch problems
4. Social/emotional delays
5. Possible other developmental delays

V. DOWNS SYNDROME

Downs Syndrome is a genetic abnormality which is generally associated with serious developmental problems. One out of every 600 to 700 children will be born with Downs Syndrome (once called Mongolism). There are myths that all people with Downs Syndrome are alike and that they are all profoundly retarded. Many studies done in the last 15 years have shown that people with Downs Syndrome show a great range in ability --from profoundly retarded to children who can be mainstreamed in school with supportive services. Most people with Downs Syndrome are moderately retarded. These studies have also shown the dramatically positive affects of beginning intervention in infancy.

B. Characteristics and health problems that may be associated with Downs Syndrome. Not all people with Downs Syndrome have all of the following characteristics:

1. Flat Faces
2. White spots on wrists
3. Straight line across the hand
4. Shorter in stature
5. Slanted eyes
6. Hearing loss and/or small ear canal
7. Congenital heart defects - may restrict activity level
8. Impaired vision
9. Hypotonicity - low muscle tone affects fine and gross motor skills
10. Thick tongue and/or small oral cavity - makes clear articulation difficult.

C. Associated Special Needs

The degree of delay in developmental areas varies with the child

1) Language (expressive/receptive), language asquisition is the most difficult area for most children with Downs Syndrome.

2) Fine and gross motor may tend to be affected due to low muscle tone, or hypotonicity; generally needs sensory motor stimulation, especially in vestibular and sensory integration areas.

3) Cognitive - early and continued intervention has been shown to enhance development greatly. They generally follow the normal developmental pattern.

VI. FETAL ALCOHOL SYNDROME

Fetal Alcohol Syndrome was identified in 1973. Longitudinal studies of infants diagnosed as having fetal alcohol syndrome indicate that they are likely to exhibit the following characteristics throughout their lives:

1. Impaired intellectual ability
2. Tendency toward hyperactivity
3. Experience difficulty with fine and gross motor skills
4. Impaired physical growth

Significant intake of alcohol by pregnant women can result in her giving birth to an infant with Fetal Alcohol Syndrome. The risk of giving birth to an infant with fetal alcohol syndrome increases with the amount of daily alcohol consumption. The quantity of alcohol ingestion and the time (with reference to the infants prenatal development) affects the degree of Fetal Alcohol Syndrome. Chronic Alcoholics tend to have the most severly affected children.

B. Infants with Fetal Alcohol Syndrome tend to:

1. be premature and have low birth weight
2. exhibit distinctive facial features (droopy eye lids, high palate, flat faces)
3. microcephalic (small head/brain)
4. have peculiarities in joints which limit movement
5. exhibit psychomotor disturbances
6. have height and weight below standard norms.

C. Intervention

Early intervention beginning in infancy is important. Those severely affected by Fetal Alcohol Syndrome will require special education throughout their school years.

VII. CYTOMEGALOVIRUS (CMV)

Cytomegalovirus (CMV) is a member of the herpes virus group; it is a common virus. CMV is currently believed to be the most common cause of congenetial infection in infants--it occurs at the rate of between 0.5 and 2.0% of all live births. Prenatal CMV infection represents a greater danger to children than rubella--because there is not effective vaccine against it. Some research suggests that CMV may be responsible for "undiagnosed" cases of continuing developmental delay. The study of CMV is international in scope, with Sweden and England having, until recently, done the bulk of the research.

A. Causes/Effects

Adults and older children with CMV usually experience fever and flu like symptoms which last a few days. CMV is only dangerous and damaging to the developing fetus.

Prenatal CMV can cause:

1. Central nervous system damage (seizures, behavioral disorders, irritability).
2. nueromuscular disabilities varying from slight awkwardness to floppy muscle tone and significant gross motor delays.
3. microceptaly
4. deafness

Children who contract prenatal CMV can experience developmental delays ranging from slight to severe.

Prenatal CMV is more common in the infants with younger mothers (these mother's didn't have a natural CMV immunity yet), with first born children and among poor people. Infants can continue to secrete the live virus (in urine and saliva) up to age five. This poses a danger to pregnant women who come in contact with the infant. The amount of live virus secreted can be measured. Most hospitals don't allow pregnant nurses to care for infants with CMV.

SIGNS OF POSSIBLE PROBLEMS IN CHILDREN

	YES	NO
Possible Eye Trouble		
Behavior		
Rubs eyes excessively		
Shuts or covers one eye, tilts head, or thrusts head forward		
Has difficulty in work that requires close use of the eyes (such as putting puzzle parts together or matching identical shapes).		
Blinks more than usual, or is irrativle when doing close work.		
Holds objects close to eyes		
Is unable to see distant things clearly		
Squints eyelids together or frowns		
Appearance		
Has crossed eyes		
Eyelids are red-rimmed, crusty, or swollen		
Eyes are inflamed or watery		
Has recurring styles (small inflamed swellings on the rim of the eyelid.)		
Complaints		
Eyes itch, burn, or feel scratchy		
Cannot see well		
Has dizziness, headaches, or nausea following close work		
Has blurred or double vision		

Yes No

Possible Hearing Loss

Medical History

Is there a history of earaches or ear infections in the child's records?

Does the child complain of earaches, ringing or buzzing in the ears?

Does the child have allergies or what appears to be chronic colds?

Has the child had a disease (mumps, measles) accompanied by a high fever?

Do parents say that they have wondered if the child has a hearing loss?

Hearing

Does the child ignore verbal directions

Is there a lack of attention (e.g. during storytime)

Does the child fail to respond to loud, unusual, or unexpected sounds?

Does the child fail to respond to communication that excites the other children? (For example "Who wants ice cream?")

Does the child frequently fail to understand or respond to instructions or greetings when he or she doesn't see the speaker?

Does the child seem to watch other children rather than listen to the teacher in order to learn what to do next?

Does the child have difficulty finding the source of a sound?

Does the child constantly turn the television, radio, or record player up louder?

Does the child's attention wander or does the child look around the room while the teacher is talking or reading a story?

	Yes	No
Speech		
Does the child frequently say "Huh?" or "What?" or show other signs of not understanding what has been said?		
Does the child use very little speech?		
Does the child have trouble putting words together in the right order?		
Does the child's voice seem too high - pitched, too low-pitched, or too nasal?		
Does the child have poor articulation?		
Other Behavior		
Does the child have a tendency to withdraw?		
Does the child have a short attention span?		
Is the child easily frustrated or distracted in a group?		
Does the child tend to play in the quietest group?		
Does the child tend to play alone more than the other children do?		
Does the child seem unaware of social conventions? For example, does the child:		
..Never say automatically "thank you," "excuse me," or "sorry"?		
..Generally tap or grap another person instead of calling his or her name?		
..Not become quite in quite areas or activities (church, story corner, naptime)?		
..Not ask permission to leave the room, go to the bathroom, get a drink?		
..Appear unaware of disturbing others with noises?		
..Does child use constant visual scanning?		
..Does child turn head to one side to hear?		

*Taken from Head Start Mainstreaming the Handicapped Preschooler.

Part IX - Observing and Recording

I. Handout 9A - Observation and Recording in the Early Childhood Classroom

II. Tape

III. Handout 9B - General Suggestions for Observing a Child.

IV. Activity 9C

V. Observation Form Examples

9A

OBSERVATION AND RECORDING IN THE EARLY CHILDHOOD SETTING

WHO - WHAT - WHEN - WHERE - WHY?

Q. Who observes and records and who is observed and recorded?

A. Observations and recordings can be, and should be, made by any personnel coming into contact with children. Adults caring for children are especially important in making observations and recordings, but many other persons can do this as well, such as cooks, caretakers, bus drivers, administrators, etc. Parents can, and often do, make observations and record behaviors. If there is a concerted effort between parents and caregivers, this can often provide the greatest benefit for the child.

Observations and records are made on children, caregivers, other personnel, and parents. Observations are also made on activities in relation to the children and caregivers.

Q. What is observed and recorded?

A. Any behavior which can be observed by another person can be observed and recorded. This can include children's behaviors, caregivers' and other personnel behaviors, and parents' behaviors. The trick here is to remember that these behaviors must be observable: one cannot observe happiness, but can observe smiling behavior and laughing, etc.

Q. When can behaviors be observed and recorded?

A. Behaviors can be observed anytime when they may occur. Adults can be easily trained to observe and record behaviors while they are engaged in interaction with the children and performing other duties. Data taking should be simple enough to enable the adult to take quick and easy records, providing accurate and valuable information. Behaviors can be observed and recorded when the children are engaged in freeplay, while snacking, toileting, cleaning up, resting, playing outdoors, in a large group, etc. The important thing is that each person doing the observing and recording be aware of the exact behavior being observed and that the recording be simple and efficient enough to provide adequate information yet be easily recorded while engaged in other activities.

Q. Where can observations be made and recording be done?

A. The Where is the same as the When: the answer is anywhere the behavior may occur. Recording can be done while helping children take off their coats, while preparing to get on the school bus, while sitting at the snack table, while sitting on the floor during group activities. Again, the important thing is to provide for a simple and efficient method of recording, and easy access to the recording materials (data sheet, pencil, clipboard, etc.)

Q. Why observe and record?

A. Observations are constantly being made in the child care setting and in related areas with young children. These observations are usually very informal, and although they provide the adult with valuable information, there are occasions when specific and accurate information is necessary.

OBSERVATION AND RECORDING THE EARLY CHILDHOOD CLASSROOM

WHO - WHAT - WHEN - WHERE - WHY?

Circumstances where a child's developmental progress is being questioned require accurate, complete data. Sometimes it takes "hard, cold facts" to convince the parent that attention must be paid to a developmental problem; sometimes the support professionals (physicians, speech and hearing specialists, etc.) require clear data in order to diagnose difficulties and then to treat them. Other circumstances such as a problem behavior which is disruptive to the group and the child needs to be dealt with. Accurate observations and records of the occurrance of the behavior can help the adult determine possible causes and cures for the behavior. Occasionally the clear data presented by observations and recordings can put a behavior into its proper perspective and a behavior which is at first seen as a problem can be seen as more annoying after the data is in. Frequently observations and records are used to help the adult see areas where children need help and to see the areas where the children's strengths lie. This is invaluable when assessing the program and its goals.

This brings us to another important "why" in observation and recording. It is important for the program as a whole to have goals for the children and parents served. It is important for the adult to have a means of assessing the program and how that program is meeting the goals. Observation and recording can provide the necessary information in this important assessment. In fact, observation and recording can be an important tool in setting the goals for the program in the first place. Observing behaviors and gaining a clear picture of where the children in a class are "developmentally" and then setting goals from that point on is an effective way to tailor-make a program for the people served. Once this has been done observations can be done periodically to assess how the goals are being met, and changes in the program can be made to better meet these goals. At the end of the program, or the time period set for the goals, the observations and records can be analyzed in terms of the effectiveness of the program. The analysis will then be used in setting goals for future programs.

Perhaps answering the who, what, when, where and why questions about observation and recording can help us, the professionals and non-professionals who work with children, better understand the importance of careful observation and recording in our work. We need to understand the children we work with, and we need to understand their behaviors and our reactions, and the goals of our programs in relation to their needs and growth in order to best serve each individual.

A. Yvonne Mendenhall

OBSERVATION AND RECORDING

THE BEHAVIORAL DEFINITION

It is very important when observing and recording behaviors, that the behavior be clearly defined. This definition is important for the observer in order that s/he can consistently observe and record the correct behavior, and it is important to others who may do observations and recording of that behavior. It is also important to anyone who may read the observations and use them, such as other teachers, center administrators, parents, and health care or other professionals.

A clear behavioral definition will state exactly what the observer will see when the behavior is observed. For example, a behavior such as standing up could be defined as an upright position of the body with the body weight resting on the feet and no other means of support visible. This excludes standing up while leaning or holding on to something. The observer, however, may want to include these behaviors in her/his definition, and could easily do so by defining standing up as any behavior which provides an upright position of the body with the main body weight resting on one or both feet, including any behviors which use holding on or leaning as part of the act.

It may seem unneseccary to define standing up as such an involved process, but if one is to be sure that other observers will record the behavior correctly, and if one is to be sure that the recorded data is to be correctly interpreted, then these definitions are necessary. There are potential situations where standing up could be an important element in a child's development and correctly observing and recording the behavior could be important.

Other behaviors are more difficult to define, and have an even broader interpretation by potential observers. Things like aggressive behavior, or withdrawn behavior, or cooperative behavior are frequently interpreted in different ways by different people. In the case of these behaviors, a clear, precise definition is more necessary, and more difficult to write! Such definitions can contain a list of the included behaviors, such as: hitting, biting, spitting, shouting, pushing, throwing, etc. in the definition for aggressive. These definitions can be, and probably should be, tailor-made to suit the child the observation concerns. That is, if that child shows agression in particular ways, these should be included in the behavioral definition and other behaviors left out. For example, if a child displays "withdrawn" behaviors by sitting alone in a corner, sucking his thumb and rocking his body back and forth, then that is how withdrawn should be defined for that child.

Each person involved in making observations and recordings should have access to the definition, it should be written out and in plain view during observation periods, and each person should be questioned to be certain that they fully understand the definition. Periodically the definition should be reviewed to be certain that "drift" is not occurring. That is, after a period of time it is common for the definition to be forgotten and the behaviors being observed to be interpreted as the definition. This is causing incorrect data to be taken, and can be disasterous!

OBSERVATION AND RECORDING

TIPS AND TECHNIQUES:

* A prepared data sheet is invaluable. It might be a good idea to plan to try the data sheet out for a session before making too many of them. Frequently it is not exactly what you want, and it takes using it to see what more or less it needs.

* Have plently of data sheets available, and easily accessible.

* Use codes for recording behaviors and responses, have the codes listed with their meanings at the top of each data sheet. Use simple codes, like an X when the behavior occurs and a - when it does not, or a V for verbalizations and a P for physical responses, etc.

* Use a clipboard for the data sheet, and tie the pen or pencil onto the clipboard.

* Get into the habit of carrying the clipboard around with you. Once you have the habit, it comes naturally. (Lots of people carry coffee cups around with them and they will tell you how easy it is to acquire such a habit!)

* Small clipboards or data sheets on pads can be clipped onto a belt loop or belt or worn around the neck for ease in use. (Use a clip ring from a loose-leaf packet to clip them on)

* Purchase small pocket stop watches for interval recording. Special clipboards can be purchased which have a holder for these watches so the recorder has more hands free.

* Read the behavioral definition every day and be sure you are still observing that same behavior throughout. If more than one person is observing a specific behavior, be sure everyone is still on the same wave length and observing and recording the correct (and same) behavior.

* Have regular and frequent staff meetings to discuss the observations and to check the data! These meetings should ideally occur every day, but they usually occur weekly. If the meetings are kept short it is easier to meet more often.

* Be sure that one person or place is designated as the recipent of all data. It is very frustrating to take the time to observe and record and then not have the information because it is lost or at home, etc.

* Prepare a simple to read and simple to use composit sheet for data and transfer data from daily sheets to the composit sheet (a graph is great) regularly. The information observed and recorded is useful, but only if it can be found and understood, and if it is in some convenient form. No one wants to thumb through 35 data sheets to count a behavior!

* When the observations are complete, write up a brief summary of the behavior and the observations. If you have initiated a program to change the behavior that should be written up also and the results of the program included. This information could be conveyed to the parents at conferences and other staff and professionals interested in the child.

9B

GENERAL SUGGESTIONS FOR OBSERVING A CHILD [1]

Be willing to just sit and look and listen. Children show us the way they feel by the way they do things as well as by what they do. They communicate with us through their voices, posture, gestures, mannerisms, and facial expressions.

Be objective. They not to evaluate what the child is doing while you are observing.

The following are some questions about the kinds of things you should try to watch for when you observe a child. As you become more skilled at observing, you will probably think of other questions and behaviors which are important in understanding a child.

1. What is the specific stiuation in which the child is operating?

   What other activities are going on? What are other children doing? What is the general atmosphere of the room (noisy, calm, boisterous, quiet)?

2. What is the child's approach to materials and activities?

   What was he/she doing just before this activity? Why did the child change activities? Is the child slow in getting started or does he/she plunge right in?

   Does the child use materials in the usual way or does he/she use them in different ways, exploring them for the possibilities they offer?

3. How interested is the child in what he/she is doing?

   Does he/she seem intent on what she/he is doing or does the child seem more interested in what others are doing? How long is his/her concentration span?

4. How much energy does the child use?

   Does he/she work at a fairly even pace or does the child use a great deal of energy in manipulating the material, in body movements and in talking?

5. What are the child's body movements like?

   Does the child's body seem tense or relaxed? Does he/she move freely or hesitently? Are the child's movements jerky, uncertain or poorly coordinated?

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1. Adapted by Sally Kilmer for the Family Day Care Training Project, 1/74

General Suggestions for Observing A Child

6. What does the child say?

   Does the child talk, sing, hum or use nonsense words while he or she works? What is the child's speech like? Does she/he use sentences, single words? How does the child communicate with others? Words or gestures?

7. How does the child feel about what she/he is doing?

   Does the child seem happy? Upset? Satisfied?

8. How does the child get along with other children?

   Is she/he eager to play with them? Unwilling to share toys?

9. What kings of changes are there between the beginning and the end of an activity?

10. What is the child's relationship with you?

    Is the child eager to see you when she/he comes? To tell you about what he/she is doing? Does the child tease?

REMEMBER THE IMPORTANT THINGS IN OBSERVING ARE TO:

RECORD EVERYTHING
BE INOBTRUSIVE
HAVE THE SITUATION AS "NORMAL" AS POSSIBLE
INTERACT WITH THE CHILD NO MORE THAN YOU USUALLY DO

Activity 9C

Choose a problem or a question that you would like more information on regarding a particular child in your group.

Observe this child during a specific 5 - 15 minute activity on 3 different days. Write down what you observed.

*Remember look for a behavior that you can observe directly.

_____

Description of problem/question I chose:

_____

_____

_____

Summary of my 3 observations:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Conclusions (<u>What</u> did I learn?)

_____

_____

_____

_____

_____

_____

_____

_____

_____

OBSERVING AN INDIVIDUAL CHILD

Name of Observer _____

Name of Child _____

Teacher _____ Date _____ Time _____ to _____

Activity while observing _____

Adjustment to School	Yes	No
--Does the child need to be reminded to hang up his coat?	___	___
--Does the child need to be directed to an activity?	___	___
--Does the child work independently?	___	___
--Does he or she show interest in the classroom activities?	___	___
--Does the child need support from the teacher?	___	___
--Does he or she know what to do?	___	___
--Does the child know what is expected of him or her?	___	___
--Does the child try new things?	___	___

OBSERVING AN INDIVIDUAL CHILD

Name of Observer _____

Name of Child _____

Teacher _____ Date _____ Time _____ to _____

Activity while observing _____

Play Activities	Yes	No
--Does the child become involved in an activity without being told?	___	___
--Does the child stay with the activity for ten minutes or more?	___	___
--Does the child switch from activity to activity?	___	___
--Is he or she easily distracted?	___	___
--Does the child get into conflicts over equipment/toys?	___	___
--Does the child prefer to be alone when playing?	___	___
--Does the child approach other children?	___	___
--Does he or she play next to other children with same materials?	___	___
--Does the child prefer to play indoors?	___	___
--Does the child prefer to play outdoors?	___	___
--Does he or she confine play to a narrow area of space?	___	___

OBSERVING AN INDIVIDUAL CHILD

Name of Observer _____

Name of Child _____

Teacher _____ Date _____ Time _____ to _____

Activity while observing _____

Social Development--Interaction with Peers	Yes	No
--Does the child seek out other children?	___	___
--Does the child seek only certain children?	___	___
--Does he or she avoid some children?	___	___
--Does the child take part in group activities with children of the same age?	___	___
--Does he or she spend a lot of time watching other children?	___	___
--Is the child accepted by the other children in the group?	___	___
--Does the child share space, ideas, and equipment?	___	___
--Does the child want his or her own way most of the time?	___	___
--Does the child take a leadership role?	___	___
--Does the child take a follower's role?	___	___

OBSERVING AN INDIVIDUAL CHILD

Name of Observer _____

Name of Child _____

Teacher _____ Date _____ Time _____ to _____

Activity while Observing _____

Social Development--Interaction with Adults	Yes	No
--Does the child go to any adult?	___	___
--Does the child go to specific people?	___	___
--Does he or she need to be physically close to a teacher at all times?	___	___
--Is the child comfortable with adults?	___	___
--Is the child friendly with adults?	___	___
--Is the child clinging?	___	___
--Is he or she demanding?	___	___
--Does the child seek adults out for comfort?	___	___
--Does the child avoid being comforted?	___	___
--Does the child ask for help?	___	___
--Does he or she take corrections/limitations well?	___	___
--Does the child resist corrections/limitations from certain adults?	___	___
--Does the child spend a lot of time watching adults?	___	___

SAMPLE OBSERVATION FORMS

The following is a collection of several different evaluation forms used to record children's development and growth. Review them, noticing the variety of ways and types of information which can be collected.

Continuous Information Collection

CIC

1. no response
   ex: Child shows no observable attention to the activity; head is down and nothing seems to interest him/her.

2. attention
   ex: Child visually, auditorily, or tactilely attends to the activity for any length of time.

3. assistance: includes physical, verbal, and social-emotional
   ex: physical - Adult guides child's hand, gestures towards something or pushes objects closer
   ex: verbal - Adult "talks" child through an activity, telling him/her what to do
   ex: social/emotional - Adult sits very close to the child, or has special rapport with the child and child responds because of that situation

*4. imitation
   ex: Adult demonstrates the desired response to the child. Child successfully performs the demonstrated task.

5. independent with verbal cue
   ex: Adult gives a verbal direction and the child performs the indicated task

6. transfer
   ex: Child performs task in familiar and unfamiliar situations and using different materials

*This item may require more subjective judgment when substituting it into the Vulpe.

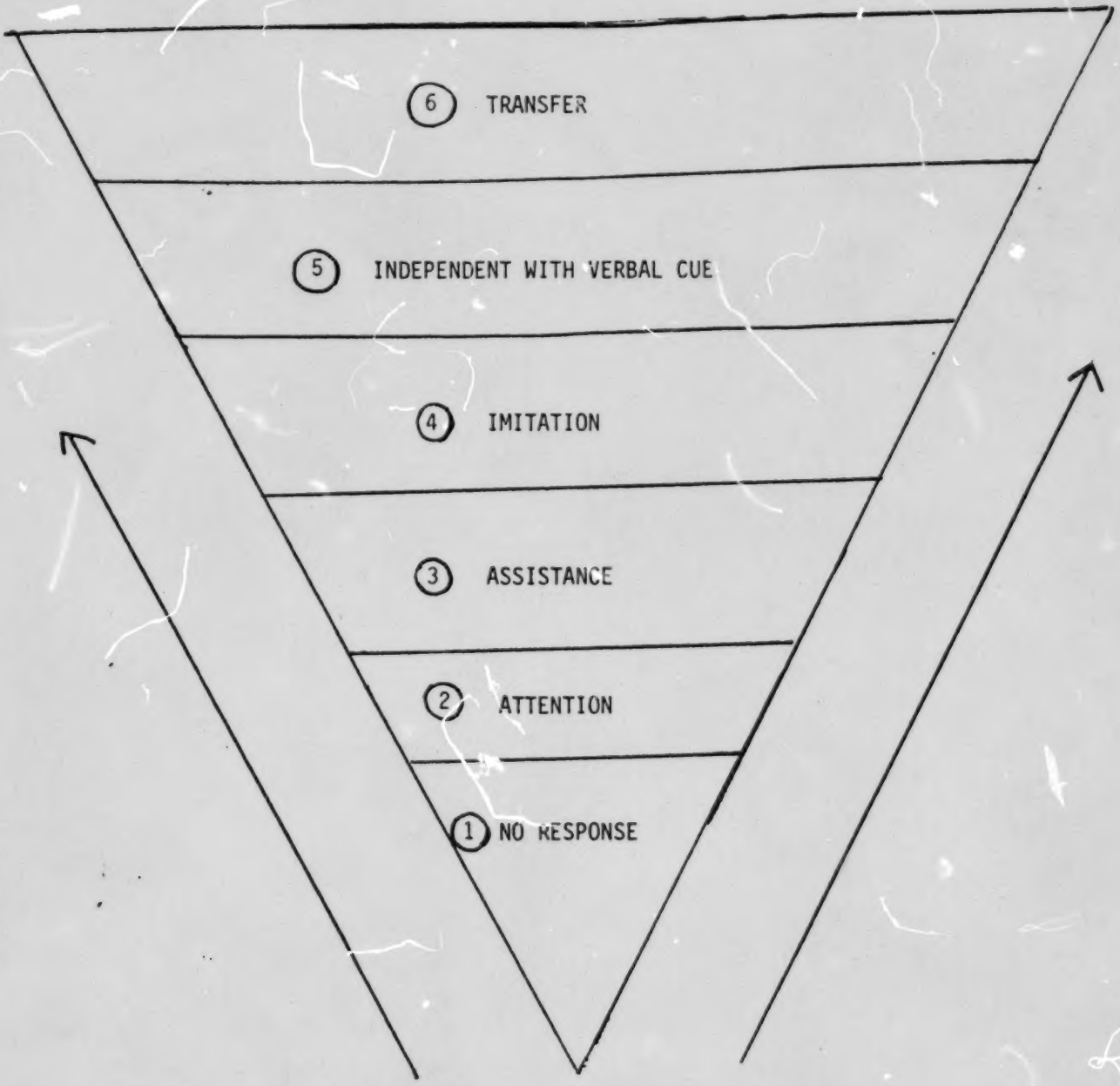
HIERARCHY OF CODES

for

CONTINUOUS INFORMATION COLLECTION (CIC)

to accompany

SPEEP Curriculum



(Activity) (Date) (Examiner)	1 No Response	2 Attention	3 Assistance verbal, physical, socio-emot	4 Imitation	5 Independent with verbal cue	6 Transfer Skills
(Name) (Name) (Name)						
(Name) (Name) (Name)						
(Name) (Name) (Name)						

Comments:

Activity: Child picks up big/little item and puts in bucket. Set up as large group - relay race. "Pick up the big block and run to the bucket!" "Which one did you put in the bucket?"

	big - expressive	big - receptive	little - expressive	little - receptive
Linda				
Debbie				
Betty				

DEVELOPED BY:
PEGGY VAN DER HEIDE
EDUCATIONAL
COORDINATOR
SE COOPERATIVE N.S.

EMOTIONAL AND SOCIAL DEVELOPMENT

GENERAL ATTITUDE self concept insecure, fearful, timid tense, moody, relaxed initially timid but adjusts quickly, confident, competent, muscle tension any special fears.	SEPARATION EXPERIENCE beginning of year: how did he react? Security object? How often does he use it? How does he come into class (directly to peer, teacher, materials) is he anxious, relaxed, does he watch others, stand alone? How does he leave mother (warm, clings, indifferent) How does he leave school: willingly, resists, finds reason to stay, cries.	TRANSITIONS conduct during transitions (organized, disorganized, tests limits, destructive, understands sequence of events? If disorganized, what helps him most? Needs adult support? Pattern behavior?	EXPRESSION OF FEELING How does he express feelings? (verbal, agressive, withdraws, to controlled? Can he acknowledge T's verbalizing of feelings? Response to frustration disappointment, anxiety. How does he recover? slow, quick?
IMPULSE CONTROL Can he accept help in self control? Excessive testing, healthy defiance, rigid about limits, passive behavior, compliance without question, frequently breaks rules, (safety). Avoids adults, makes excessive contact with all adults, including strangers.	PROBLEM SOLVING persistent, easily defeated and leaves sit. Can ask for help, can act on suggestions, defers to others? Attempts increasingly complex ways to use materials; finds own solutions; can make choices and decisions; does he attempt tasks too difficult or only when success is certain?	TURNS-SHARING-EMPATHY No sharing (takes all or gives all). Doesn't wait for turns. Shows concern for and understanding of others feelings and points of view.	APPROACH TO CONFLICT Submissive - takes no verbal or physical action Fights back (physical or verbal). Observes others defending self (from distance). Gives in but asks for help from teacher. Finds mutual solution or defends self if can't solve. Does he respond to conficts of others.
GROUP PLAY Plays alone exclusively, actively avoids peers, enjoys play with others, is successful in seeking peers; who does he play with? special friend? Is he a leader, passive follower, is he controlling intrusive? are social contacts appropriate?	INDIVIDUAL PLAY Can't play alone, Dependent on adults to provide task. Does he initiate independent play? for how long?	RELATIONSHIP TO TEACHER As resource, for emotional support, How does he ask for help? In what situations? Does he seek adult rather than child? Attitude toward adult: affectionate, trusting, susp suspicious, abusive?	DEPENDENCY - SELF CARE Skill in self care? Can he dress self? Does he attempt but fails and ask for T's help? Is he dependent on adult for self care? Does he resist self care? Does he show pleasure in self care?

Specific Objective:

(Date)_____(Name)_____

Example: Toilet-training

	12/1/79	12/2/79	12/3/79	12/4/79	12/5/79	12/8/79	12/9/79	12/10/79	12/11/79	12/12/79	12/15/79	12/16/79	12/17/79	Comments:
Step I: (Ex: Child goes into bathroom with adult).														
Step II: (Ex: Child pulls down pants).														
Step III: (Ex: Child sits on potty).														
Step IV: (Ex: Child indicates when wet or soiled).														
Step V. (Ex: Child goes with other children into bathroom														
Step VI:														

Part X - Goal Setting and Planning Activities

I. Tape

II. Handout 10A - Setting Goals

III. Tape

IV. Handout 10B - Goal Setting

V. Handout 10C - Planning Activities

VI. Activities - 10D, 10E, 10F, 10G, 10H

10A

SETTING GOALS

Definitions

Long Range Goals - broad, general goals which can cover a period of weeks or months.

Short Range Goals - Developed out of Long Range Goals and are more specific. These can be worked on daily or weekly.

Note: State goals/objectives in terms of the skills or behaviors that the child needs to learn and that you can observe. Set a target date for when each goal will be accomplished.

A goal needs to be written stating:

Who (eg. child's name) / Will do What (eg. identify numbers by name) / How or In What Way (eg. When shown written numbers on cards) / By When (eg. In 2 months)

Make sure you've decided beforehand how you'll know when the goal you've set is achieved

Examples of Long and Short Term Goals:

Long Term Goal: By May, Tommy will improve cognitive skills in the area of number concepts by being able to recognize and count 1-10.

Short Term Goal: When given printed numbers 1-3 and a specific number of objects (eg., 1, 2, or 3 Teddy Bear Toys, Tommy will match the printed number to the corresponding number of objects.

10B

GOAL SETTING

Questions to ask to assess your planning, organization and interactions with children.

THE PHYSICAL ENVIRONMENT

- Are all the center's materials out all the time? Can they be rotated?
- Do you have a problem with children getting out teacher materials you don't want them to have? If so, how can materials be blocked off when not in use?
- Does the room appear cluttered?
- Can children get from one area to another without walking through someone else's play space?
- Is there a quiet corner in the room? Are there "private" spaces (lockers, cubbies)?
- Do children become restless and disinterested because they have to wait for materials or activities?

SNACKS, LUNCH, NAPS, TOILETING

- Do the children do a lot of things themselves during lunch or snacks (pour, mop up spills, scrape trays, set the table?)
- Are cots ready when the children are or do they have to wait?
- Is there a clear indication as to when the quiet time is to begin?
- Is there a consistent procedure for handling children who are disruptive during naptime?
- Would "star" charts help as motivators?
- Is there a scheduled time to teach self-help skills?

TRANSITIONS

- Does each child know what he or she is suppose to be doing at a given time?
- Do all children change activities at the same time or are children rotated?
- Are slower children given enough time so that they are not rushed?
- Does any child have to spend time doing nothing but waiting?
- Are children encouraged to help each other?
- Do more than four children wash hands, brush teeth, etc. at one time? Are the others busy while waiting?
- What skills can be taught or incorporated into transition times?

SCHEDULING AND PLANNING

- Is there a scheduled time for staff to plan daily activities? How often?
- Are activities planned based on your interests, a given curriculum, the child's needs, and current level of performance?
- Are developmental principles and guidelines ever used in aiding planning?
- Are the individual goals incorporated into daily activities and routines?
- Do they include statements of how to get children involved or how to correct?
- Does each staff member have a scheduled time for breaks and for planning and/or preparing materials?

INDIVIDUALIZATION

- Are each child's skills assessed in the basic areas of motor, cognitive, social and language level?
- Are the assessments used as a basis to plan the daily activities for the entire group, i.e., integrating individual needs into group plans?
- Are most of your activities planned with several "levels" of difficulty?
- Does each child have individual objectives or goals that the staff is working toward?
- How are these implemented? One-to-one, small groups, large groups?

DEVELOPMENTALLY APPROPRIATE ACTIVITIES

- During most activities, is each of the children interested and directly involved?
- During most activities, are most of the children capable of doing the activity with little or no teacher help?
- Are all the children expected to do the same activity?

  Never 1 2 3 Always
- Do you often wonder what kinds of things you should expect of children at different developmental levels?
- When a child is having difficulties, can you break down the material or activity to the child's level?

RECORD KEEPING

- Are some records kept on children?
- What kind (medical, written informal, checklists, formal assessment tool, other)?
- Are you involved in keeping records?
- Are records used for planning? Are they functional in determining problems and progress?

- Are observations made when a child enters the program?
- Are observations made to determine progress?
- Are you satisfied with your current record-keeping system?
- Could the system be made more functional?

TEACHER INPUT

- Are you satisfied with the way most of the children behave?
- For what action do you praise children (be specific; give an example from the last few days)? What do you say?
- When you praise children, do you tell them what it was that they did correctly?
- Do you think you say more positive things or negative things to the children?
- Can you list at least two "good" things each child did every day? (Do you let each child know that you noticed, through a smile, hug, wink, or comment?)
- Are there some children you do not feel comfortable with? How do you react to them (ignore, call down, smile, tolerate)?
- How can you change your behavior to become more positive?
- Do children usually follow the instructions you give?
- Do you have to repeat instructions several times?
- Do you have the environment structured so that it cues children as to what is expected so that fewer instructions are needed?

Adapted from "Pinpointing teacher goals to assist in a successful preschool classroom" by L. Jennifer Ashton-Lilo, M.A., Topics in Early Childhood Special Education, April, 1981.

PLANNING ACTIVITIES

Handout - 10C

At times children cannot be working on the same task as a group so it is necessary to set up different work tasks for each child within a group. Think of a system or organize each child's tasks. Some examples follow:

1. One provider purchased office stacking baskets for each child. Each basket was labeled with the child's name and every morning the provider would place the materials in the basket that that child should work on that day. At table work time each child received his own basket with his own materials in it. This allowed the children to work on their own specific needs. For example, one child worked on stringing beads while another practiced drawing triangles, and still another did color matching.

2. Another provider invented what she called "mat time." Each child had a mat and all the mats were arranged in a circle at mat time. The provider placed each child's materials on the mat and then worked from the middle of the circle so that she could quickly reach any child who needed help. Each child brought completed tasks to the middle of the circle for checking and was then allowed to go to free play.

The following items can usually be found in the home and some ways that they can be used.

Boxes	Clothespins	Socks	Buttons
Shoes	Cards	Silverware	

Did you think of these?

Household Item	Activity
A set of (5-6) of different-sized boxes	Nesting activities, size graduation, tower building
Socks	Sorting, classifying by color, size etc.
Silverware	Setting table correctly, sorting by type, size

Household Item	Activity
Shoes and laces	Lacing activities, learning to tie
Clothespins/clothesline	Attaching pins to line, attaching clothes, other objects to line (fine motor)
Playing cards	Sorting by suits, numbers, number recognition
Buttons	Sorting by size, color; counting (number concepts)

CC:EEN Project/Wisconsin/1979

ACTIVITIES

10D, 10E, 10F, 10G, 10H

Please complete 3 of the following 5 activities.

10D - Write a lesson plan for the Special Needs child in your care or another child of your choice.

Include:

a) Objectives/goals of the activity
b) Materials needed
c) Steps for completing the activity
d) Results

How were you able to meet the objectives for the Special Needs child within the group?

10E - Choose an individual child in your care. List the child's:

a) Favorite skills
b) Best skills
c) Problem areas

10F - Write 3 Long Range Goals and 3 Short Range Goals for a child in your care.

10G - Describe several ways a box of multi-colored, wooden one-inch cubes could be used with each of two children. One child functioning at a developmental age of 3 years and one child functioning at a developmental age of 5 years.

Activity 10H

A questionnaire on learning styles follows. Fill out the form for one child. Hopefully, you will gain some helpful insights. Perhaps you'll want to do it for the rest of the class.

Learns best when the classroom/home group is:

_____quiet
_____bright
_____warm
_____structured
_____active
_____dim
_____cool
_____open

Attends best when this approach is utilized:

_____auditory
_____visual
_____kinesthetic (movement)
_____multisensory
_____tactile

Handles an activity best when it is:

_____structured
_____programmed
_____short
_____flexible
_____free choice
_____long

Participates best when he works:

_____alone
_____with another child
_____with an adult
_____small group of children
_____large group of children

Learns best when he can:

_____stand
_____kneel
_____sit
_____lay
_____move around

Performs best:

_____in the morning
_____before eating
_____in the afternoon
_____after eating
_____in the evening

PART XI - Task Analysis

I. Tape

II. Handout 11A - Task Analysis

III. Handout 11B - What does a Child Learn from Play?

IV. Activity 11C

TASK ANALYSIS

Task analysis refers to choosing a long-term goal and breaking that goal into several sequential smaller steps. The goal for the child is determined based upon his/her present skill level and individual learning rate. For example, a goal for a child who can match colors, but is unable to name any might be to teach the child to name two colors upon request. Depending upon the child's rate of learning and his/her present skill level, this goal may take a considerable amount of time to accomplish. To assure that the child is successful, you would break the task down into a series of smaller, sequential steps which the child could achieve in a shorter time. This procedure aids in clarifying what you want to teach and provides a step-by-step progression for the child in attaining it.

The process of task analysis often involves changing the amount and type of help needed. Three types of conditions or aid are physical, visual, and verbal. The following example shows how by changing the conditions, the task becomes progressively more difficult and closer to the goal.

GOAL: Jane will draw a square upon request.

PRESENT SKILL LEVEL: Jane can grasp a crayon and draw a circle.

Physical	1.	Jane will trace over a square with mother guiding her hand.
Visual	2.	Jane will connect dashes to complete square.
Visual	3.	Jane will copy a square.
Verbal	4.	Jane will draw a square with verbal cues, "across-down-over-up".
On Request	5.	Jane will draw a square upon request.

Reference: Portage Project

WHAT DOES A CHILD LEARN FROM "PLAY" ?????

In the BLOCK CENTER, the child:
- -develops his large and small muscle control;
- -improves his eye-hand coordination;
- -explores spatial relationships and comparisons of sizes and shapes;
- -plans and solves problems while working with other children.

In the HOME CENTER, the child:
- -makes decisions;
- -imitates the people he knows...their work... their feelings... their words... their environment;
- -develops his five senses;
- -increases his understanding of his world and where he fits in;
- -uses and practices expressive language.

In the DRAWING CENTER, the child;
- -develops eye-hand coordination and small muscle control;
- -tries to use proper pencil and scissor grips consistently;
- -experiments with form, line, movement, shape and spatial relationships;
- -uses his creativity to plan, design, and implement an idea.

In the GYM CENTER, the child;
- -develops muscular strength and coordination;
- -experiments with locomotor activities;
- -strengthens his agility and balance;
- -relieves his tensions and uses his energy constructively and imaginatively.

In the LISTENING AND MUSIC CENTER, the child;
- -experiences a variety of rhythms and tones;
- -learns additional memory skills;
- -differentiates among sounds;
- -expresses himself through creative movement, rhythm instruments, and singing;
- -listens to literature and music;
- -assimilates new concepts and vocabulary.

In the PUZZLES CENTER, the child;
- -develops eye-hand coordination and small muscle control;
- -works with a whole object and its parts;
- -sees the interrelationships between sizes and shapes.

In the GAMES CENTER, the child;
- -develops his eye-hand coordination and small muscle control through the use of a variety of manipulative materials;
- -forms sets of objects;
- -identifies shape;
- -associates number concepts and numerals;
- -sequences numerals, pictures, and stories;
- -matches numerals, letters, textures, colors, shapes, sizes;
- -reproduces patterns and designs;
- -explores one-to-one correspondence.

TASK ANALYSIS

Activity 11C

Present Skill Level: Can squeeze water out of a sponge.

Goal: Cuts out a circle (3" in diameter) without help within 1/4" of line.

Arrange (number) the 7 steps in order:

_____ Snips for 3" along edge of paper without help

_____ Snips for 3" along edge of paper in imitation

_____ Cuts out a circle (3" in diameter without help within 1/4" of line

_____ Opens and shuts double scissors with physical assistance.

_____ Opens and shuts double scissors with verbal directions, "open, shut"

_____ Cuts on straight line for 3" without help within 1/4" line.

_____ Cuts on curved line for 3" without help within 1/4 of line.

11C Answers

Answers
4
3
7
1
2
5
6

BREAKING DOWN TASKS

Handwashing

Steps

1. Turn on water.
2. Put hands under water.
3. Pick up soap.
4. Rub hands together with soap.
5. Put down soap.
6. Rinse hands under soap.
7. Shake hands.
8. Pick up towel.
9. Wipe hands dry.
10. Put towel in wastebasket.

Cutting with a Knife

Steps

1. Pick up fork with left hand.
2. Stick fork into meat with left hand, and hold fork.
3. Pick up knife with right hand.
4. Holding knife in right hand, saw across meat to cut.
5. Cut one bite-size piece,and put knife down.
6. Switch fork to right hand, eat meat, put fork down.
7. Repeat process til meat is gone.

The child can be taught each small step at a time. This may be just as much as he can master at one time. You have given him a small step that he can be successful on and be reinforced. Immediately reinforcing him for each step he achieves insures that he will keep working and eventually master all the steps - the whole task.

Let's see how well you can break a task into small steps. Try this:

Toothbrushing

Steps

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

PART XII - Environment

I. Tape

II. Handout 12A - Example

III. Handout 12B - Example

IV. Handout 12C - Thinking about the Environment

V. Handout 12D - Floor Plans

VI. Handout 12E - Checklist of Materials for Learning Centers

VII. Activity 12F - Evaluating Settings for Learning

ENVIRONMENT
Handout 12A

A group of special needs four year olds were particularly distractible. Several of the children, when frustrated by an activity, tended to dump their toys on the floor. By the end of the morning puzzle pieces, blocks, pegs and other toys were scattered across the room, making for a long, tedious clean-up time.

In discussing this the teachers decided to do several things. One was to limit the number of small toys that were available at any one time. Another was to provide pieces, say pegs for pegboards, in amounts the children could manage without becoming overly frustrated. It was decided to have a teacher close at hand while children played at these activities. In effect, the adult simplified the environment bringing it more into line with what this particular group of children could manage. Thus, general group goals were met, which included providing opportunities for the children to experience success with a minimum of frustration.

ENVIRONMENT

Handout 12B

In another group of three and four year olds dramatic play occupied much of the children's time, although in a rather limited way.

The housekeeping corner was set up across the room from the sink and the dress-up clothes and props were in-between. With all the coming and going among these three areas interest was diverted, much water was spilled and dramatic play fell into predictable patterns. The teachers, this time with the children's help, did some rearranging. The housekeeping area was joined with the dress-up clothes and props to make one larger yet more cohesive unit which was also closer to the water. The result was that more elaborate role-playing developed and for longer periods of time. Being closer to the water, less was spilled and children's interest was not diverted on the way. A simple rearrangement had resulted in a more satisfying playtime for everyone.

Environment

When thinking about your family day care home or day care center environment include the following:

1. The ratio of adults to children.

2. The routines, schedules and transitions that are followed during the day.

3. The length of day or time of day children are in the day care home or center.

4. The arrangement of the physical space.

5. The toys and other materials and how they are arranged.

The ways in which home, centers and play yards are set up can result in certain kinds of behaviors and expectations. This applies to both children and adults.

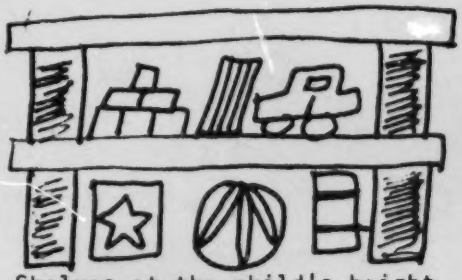
ENVIRONMENTS - Ann Carlson
Apartments, Homes, and Yards as Spaces
for Childrens' Play

Where do children play at your house? The following suggestions have proven helpful to mothers and teachers of young children. Many of them ask you to make the most of what you have for children's. Let's explore the possibilities of what you can do.

A. "What Can I Do?

1. Young children need to see their choices or they don't remember them.

The child can't see his/her choices.



Shelves at the child's height
a) tri-board (strong; cheap)
b) bricks; concrete blocks

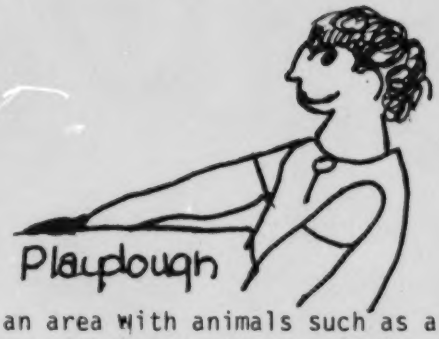
2. How to figure out if there's enough to do:*

a) "simple activities"" One Thing.

A toy that has only one use offers less possibility to manipulate or improvise. Examples: swings, jungle gym, rocking horse, tricycles, roller skates, books, teddy bear.

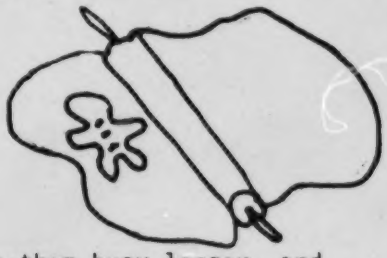
*This method was developed by S. Kritchevsky, E. Prescott, and L. Walling for preschool center care. Their book: Planning Environments for Young Children: Physical Space (NAEYC, 1969, was written for teachers, but I have found it applies well to care in home "settings" as well.

b) "complex activities": One thing



A toy with two or more parts or of different play materials which enable the child to use their imagination. Example: sand table with digging equipment, play house with supplies, all art activities such as dough or paints; a table with books to look at; an area with animals such as a dog, guinea pigs, or ducks, a magnifying glass with bugs, stones, plants, etc, things with variety of textures.

c) "super activities": Three or more parts that a child can put together in different ways. Example: sand box with play materials water, funnel, moveable climbing boards, boxes and crates; blankets, chairs, folding table, blocks, cars, and trucks.



A "super" unit interests the most children, keeps them busy longer, and allows the children to be more creative. There's nothing wrong with simple toys, however, one needs to be aware that they will keep the child's interest for a short period of time.

d) As we select toys we need to keep in mind:

--How many things can the child do with each toy?
--How long (how many years) will the toy be used?
--How long (how many minutes) will the child play with the toys each time the toy(s) is used?

3. Life can be sweeter when you make the most of your space. We often set up children to misbehave (for example: "Don't run your car over Susie's book when she's reading") If we take the time and effort to be more flexible, it can prove to be well worth the effort.

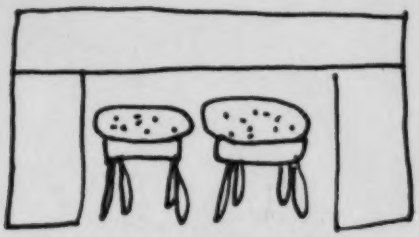
B. Now, let's look at your play space. Well planned space can help the children play together more cooperatively.

1. Are quiet activities protected from noisy ones?

2. Can children walk around without walking <u>through</u> each other's games? If not, how about moving your furniture around?

Furniture can separate activity areas, make private corners <u>outside</u> the traffic pattern, and create neat places to play.

Give children a workspace for puzzles, etc, with a throw rug. Each child can have their own color. No trespassing! (Put the rug where others won't be tempted to interrupt him/her for example, avoid halls, doorways, the front of the toyshelf.)



An old table with the legs cut down and painted attractively makes a good work top for art activities, puzzles, etc.

Old chairs, can also be cushioned and cut down. If you remove the backs, they can be stored under the table. (Toddlers like to work standing up.)

Contact paper makes a washable table surface.

Can the children see where toys should be used? Can each see his/her own space? (A placemat helps.)

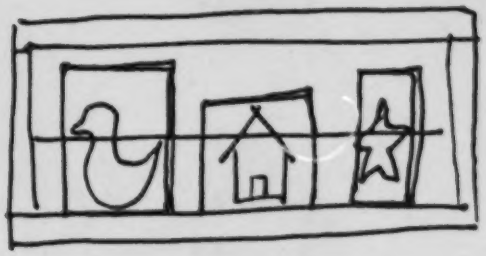
Books are not often destroyed if kept in a quiet, comfortable area.

Can an adult sit cozily with the child to read?

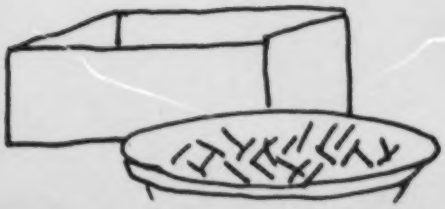
Try taking some books out on a blanket in the shade on hot days.

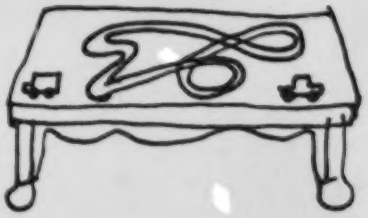
When the children can see the book covers, they find them much more inviting!

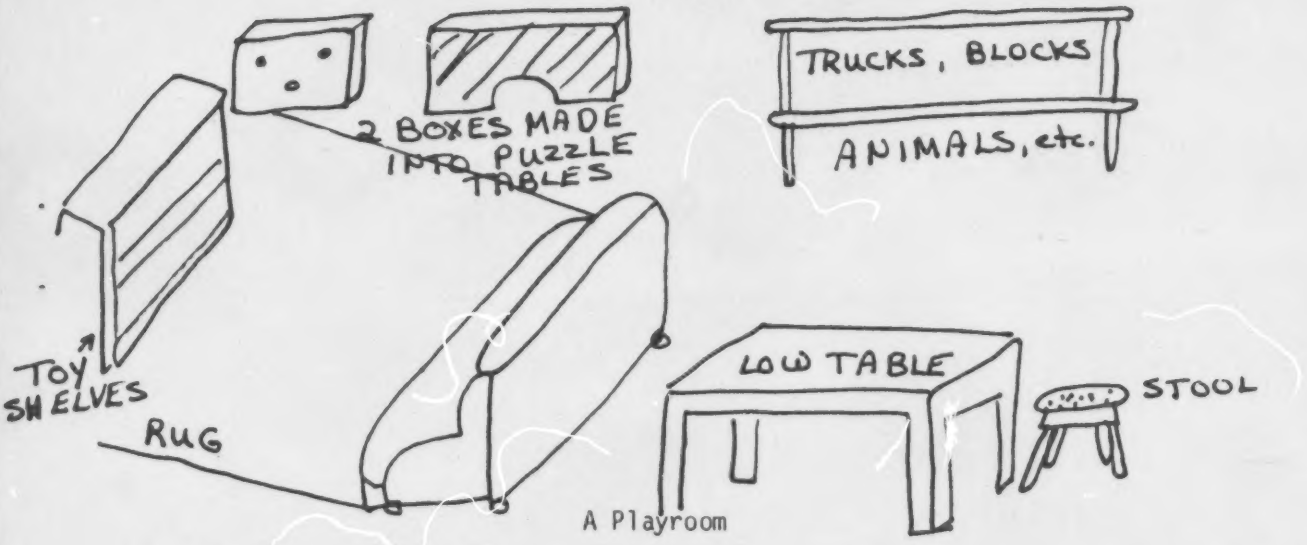
There are many cheap ways to arrange this type of display or use a window sill, a table, or fewer books, displayed face front on a shelf you already have. Use sturdy plastic.



3. Have your children found a large, empty space where they seem to chase and fight? Can you set up 1) barriers (to cut the running) or;
   2) play ideas which they can see (to give them ideas of what you would like them like them to do)







A Playroom

4. Get down on your knees. Can you see the toys, the "pathways" between games, the pictures, plants, etc? What is it like to be as tall as a child in this space? Your notes:

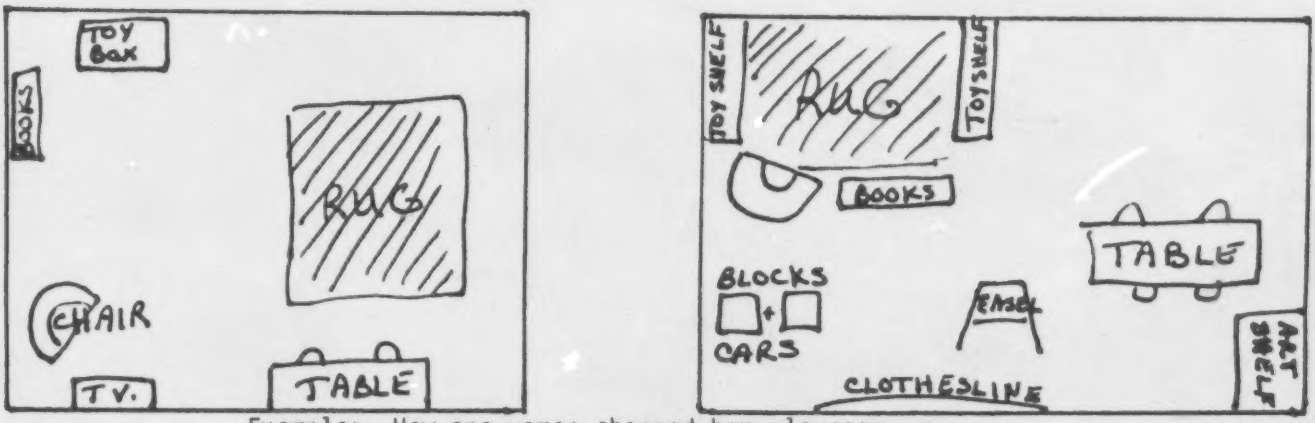
5. Can the child be as independent as possible?

Is it easy to see where things should be put away? (children love a "system" for where things should go) This also teaches orderliness. Pictures cut from catalogs can help the child see where things belong.

6. What playspaces do you use that are outside the home, apartment, or yard space? (lanudry room? Playground? Library? What else?)

TO BE DONE LATER:

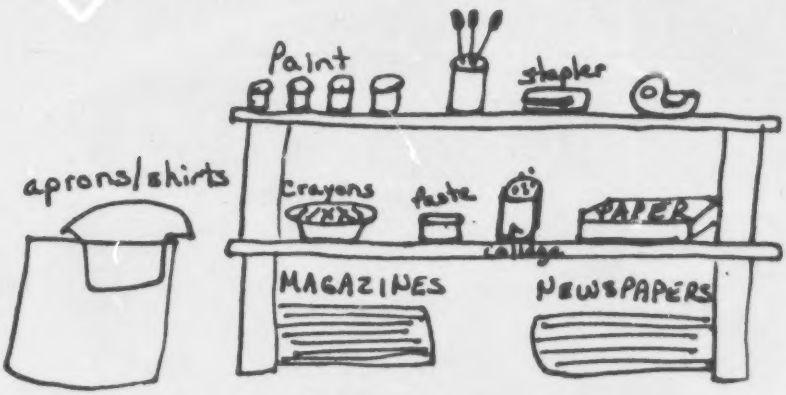
1. What have you changed? Write and/or sketch for us your space "before" "after".



Example: How one woman changed her playroom
(and it kept on changing...)

Sample "Super" Activities: are things combined into groups as they will be used? These will hold children's attention for a LONG time!

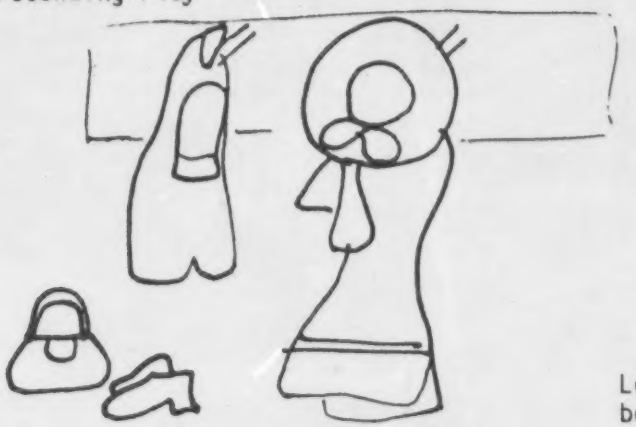
1. Art project shelf - Can be made from large blocks & boards, purchased from a garage sale or Goodwill, use shelf brackets behind a door, or they can be constructed from cardboard, tri-wall, or whatever you have.

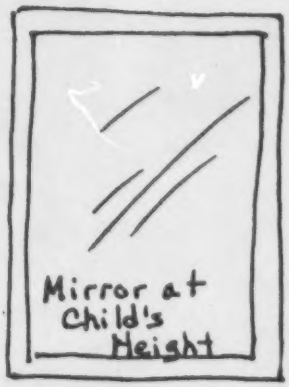


A. In plastic jars or yogurt cartons.
B. An old pie tin or coffee can or other carton lets the children see them, makes clean up easy.
C. Fabric, paper scraps, pine cones, macaroni, yarn, tin foil, etc.
D. Children are just as happy to pain on newspaper or grocery bags as easel paper! You can even make a cardboard box easel.

(Make sure the children know where you want them to work with these things!)

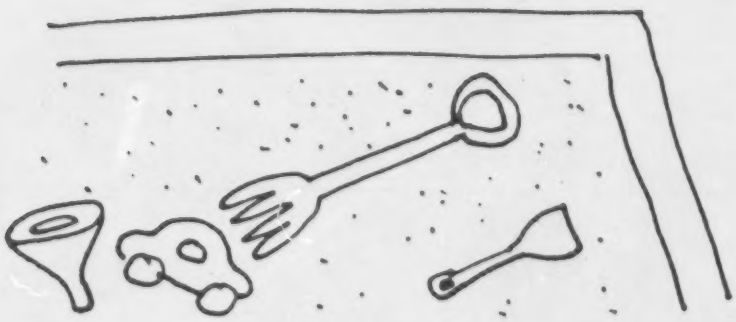
2. Pretending Play





Lots of props can be made from boxes or purchased at the Salvation Army.

3. Play with sand, water, and clay.



Sand play lasts longer and has more possibilities for learning if you sometimes ass:

- trucks
- animals
- small dolls and furniture
- water
- metal dishes (cheap from Goodwill - last longer than "cute" pails and shovels)
- unbreakable kitchen utensils (sieves, eggbeaters, funnels, etc.)

You can use all the sand ideas for water play (try the bathtub if your's nervous about splashes). Also for <u>water</u>: add soap -

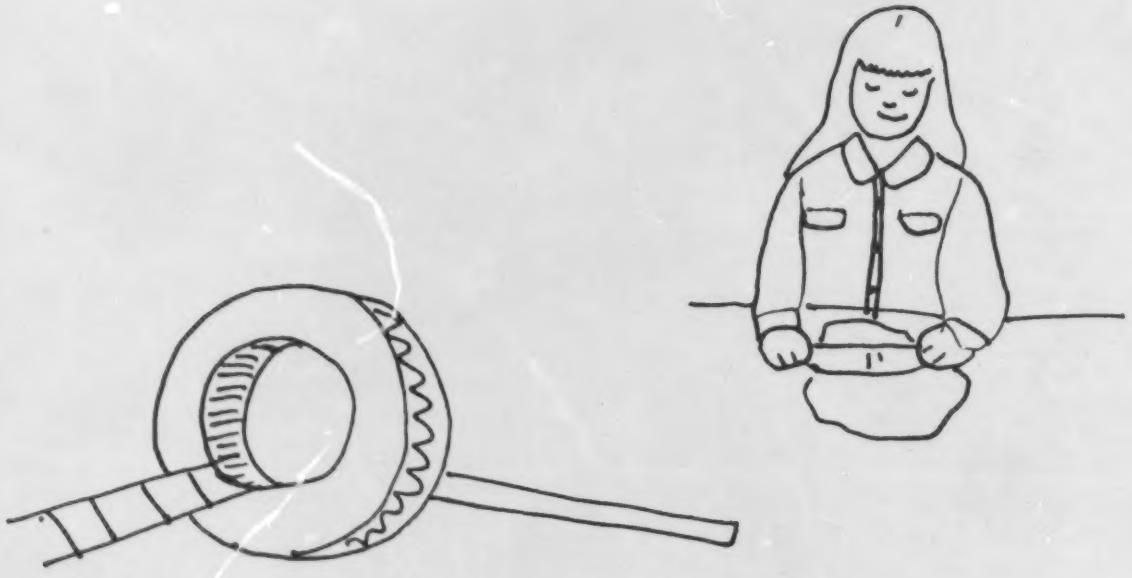
a) straws to blow bubbles (detergent in a cup works well, make sure children know they shouldn't swallow).

b) dolls, doll clothes, dishes.

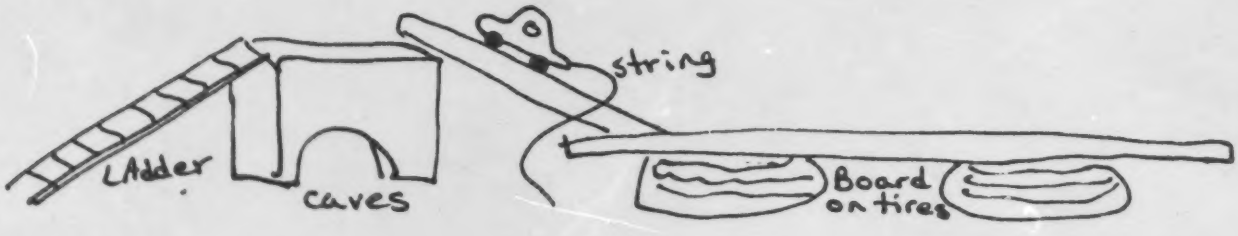
Let the children use the rolling pin, cookie cutters and silverware with playdough.

They also like things to <u>stick</u> in lumps of playdough (pipecleaners, soda straws, twigs, etc.)

4. These simple materials can be rearranged lots of ways by children for outdoor play. (If you find they make your yard look mess, have the kids help you pick them up after use - if they can move them to play with, they'll be able to move them for storage. Don't be afraid to spend 10 minutes "setting up" and "cleaning up". You will be repaid by a long happy playtime for kids with more things to do.)



5. Small blocks get used new ways when you add:
   - cars and trucks
   - small animals
   - people and furniture
   - scissors, crayons, and paper to make "maps", signs, etc.



ENVIRONMENT

Checklist of Materials for Learning Centers

Language/Cognition and Readiness Center

books
reading skills kits, games
flannel boards and cutouts
large alphabet blocks
puzzles
sequence cards
pictures and objects for classifying
magazines and catalogs
poems and story starters
word boxes
typewriter
feel box
magic slates
word cards
filmstrips, tapes, records
manipulative divices for visual discrimination and motor coordination
child-made books
puppets
viewmasters

Block Center

set of solid wodden blocks
set of hollow-ply blocks
riding wheel toys
rubber zoo and farm animals
rubber people
small vehicles (airplane, dump truck, firetruck)
block bin/shelf
traffic signs
steering wheel

Math Center

counters (blocks, beads, sticks, straws buttons, clothespins, bottle caps)
scales and objects to weigh
rulers, yardstick, tape measure
clocks
measuring devices - spoons, cup, quart
games
bead or counting frame
cuisenaire rods
number lines
balances
play money
pegs & boards
dominoes

Creative Dramatics

puppets and theater
brooms, mop, dustpan
brushes
clothes rack
dish pan
child-size, stove, refrigerator, cupboard
small table, chairs
small rug
chest for dress-up clothes, shoes, hats
dolls
doll clothes, beds
cooking utensils
sponges, clothes
doll carriage
dishes, silverware
mirror
rocking chair
curtains
artificial foods
telephone
ironing board, iron
pails
jewelry, shoes handbags, hats, coats, dresses

Music and Rhythm Center

rhythm instruments
small boxes
dowel sticks
record player
records
earphones
autoharp
scarves for dancing
materials for children to make their own instruments (boxes, paper plates, bottle caps, stones, beans, can, etc.)

Art Center

materials for weaving, stichery
box of materials for collages
bags
stocks
art prints
box of paper scrapes and material scraps
wallpaper samples
aprons, old shirts, or smocks
orange juice cans
corn strach, laundry starch
flour, salt (for play dough)
drying rack
colored toothpics
cacke tins for modeling clay
containers with lids for mixed paints
clay boards
food coloring
buttons, macaroni, nuts
wood scraps
scissors
paint
paste
glue
tape
rubber cement
tempera
stapler
magic markers
pencils
finger paint
colored chalk
easel
pipe cleaners
yarn
water colors
clay
brushes
crayons
construction paper
finger painting paper
art tissue
crepe paper
corrugated cardboard

Indoor/Outdoor Motor Centers

sand and water play table with top
alunimun sand utensils
jungle gym
tire swings
platforms
large sewer pipes
tree trunks
low turning bars
low horizontal ladders
safety climbing ropes
wading pool
walking boards
sawhorses
ladders
wooden steps
heavy wodden benches
low balance beams
tires
balls
beanbags
jump ropes
tools for gardening
tools for woodworking
large packing boxes

12F

ENVIRONMENT

"Evaluating Settings For Learning" [15]

It is very helpful when evaluating your setting to look at the enviornment from a child's point of view. everything present in the environment, even the special arrangement, communicates to the child how to live in that setting. Materials that are in good condition and placed far apart on open shelves tell a child that the materials are valued, that they are meant to be considered, and that a child may take them off the shelf by himself.

Evaluation Checklist

	Yes	No
1. Can quiet and noisy activities go on without disturbing one another? Is there an appropriate place for each?		
2. Are activity centers defined so that children know where to use the materials?		
3. Is self-help encouraged by having materials in good condition and always stored in the same place?		
4. Are setup and cleanup simple? Are these expected parts of the child's activity?		
5. Is the children's work displayed attractively at the child's eye level?		
6. Do the children feel in control of and responsible for the physical environment?		
7. Is the physical environment enough under control so that the major part of the adults' time is spent in observing or participating with children?		
8. Do children feel safe with one another?		
9. When limits are placed, do adults use reasoning and consistenty follow through? Are limits enforced?		
10. Is there an overall warm interpersonal environment?		
11. Are there some opportunities to follow patterns or achieve pre-determined goal: puzzles, design blocks, dominoes, matching games?		

	YES	NO
12. Are field trips planned to give experience with the world around us? Is there adequate preparation and follow-up after trips?		
13. Are there repeated opportunities for children to use similar materials? Are materials available in a graded sequence so that children develop skills gradually?		
14. Can children see their choices clearly?		
15. Can children walk around without walking through each other's activities?		
16. Is it easy to see where things should be put away?		
17. Does each child have a place to hang his/her coat, put pictures and projects for taking home, etc.?		

PART XIII - Parents

I. Tape

II. Handout 13A - Guidelines for a Partnership with Parents

III. Handout 13B - A Working Summary of the Grief Process

IV. Handout 13C - Parents

V. Handout 13D - Parents

VI. Tape

How To Talk To Parents When You
Suspect A Problem

This handout is designed to give an outline of steps to follow and some helpful hints to consider before approaching parents of children with suspected special needs.

These four major steps are covered in greater detail:

"It's ECEE"

1. Establish a routine communication system with parents.
2. Collect facts about the problem through observations.
3. Express concerns.
4. Encourage outside support or help.

I. Establish a Routine Communication System With Parents - Every Parent.

A. Ways to make contact:

1) Daily, weekly, monthly.
2) Can be made through:

a) phone calls
b) notebooks sent back and forth from center to home
c) notes
d) labeling directions of art projects sent home so that parents are aware of directions
e) Happy-grams
f) personal chats before or after pick-up and drop-off
g) conferences

B. Considerations

1) Time of day that's most convenient.
2) Approach of contact (2 above) that best fits their needs.
3) Which parent is easier to approach?
4) If bilingual, does one parent seem more fluent in English?

II. Preparing for Parent Meetings.

A. What do we know about those with whom we will be talking? Parents are people.

1) Parents have limitations - financial, time, & coping.
2) Parents of children with <u>known</u> problems have been, are, or will be dealing with feelings of anger, frustration, confusion over conflicting statements from a variety of so called "authorities".
3) Parents of children with known problems may be looking for THE ANSWER - when often there is none.
4) Parents may go through a continuum from feelings of hope to feelings of despair.
5) Each parent brings a life style - cultural influences, demands from other stresses, methods of coping with and solving problems or emotional strength.
6) Parents see their children as extensions of themselves and therefore feel vulnerable because they assume responsibility for however the child turns out.
7) Parents are often fearful because the child is unpredictable and therefore, the fear of the unknown exists.
8) Some researchers feel that parents of special needs children go through a grieving process as much as anyone who has experienced a loss. They are experiencing the loss of a "normal" child. (see attached handout for that scale) Ask yourself where the parent might be in that process.

B. Know the purpose of each contact with a parent.

1) What do you wish to say?
2) Do you have enough <u>facts</u>, not opinions, to support what you wish to say?

3) What factors might inhibit communication?

C. Be aware of your own feelings toward each parent, child, and yourself.

1) Blame, anger, sorrow, nervousness, fear of loss of a client are all understandable, but they are all feelings which have no place in sharing information.
2) Focus on the child's needs in relation to your center, school, or home, not on family feelings.
3) Be supportive and sympathetic, but be aware when parents make demands or express feelings you are not trained to deal with (we are not social workers). State your support, but suggest outside family help such as counseling etc.
4) Don't sell yourself short. You've seen lots of kids. Look at child development. Have a good resource to check.
5) Know your own limits. Do not feel a burden to diagnose. Only physicians have that privilege.

III. Collect Facts

1. Make written observations - write dates on every observation.
2. If possible, use other staff for observations for support.
3. Stick to facts - what you can see, hear - don't collect opinions. (Refer to packet on observations in handouts)

IV. Now It's Time To Talk

A. Your Turn

1) Describe observations.
2) State your concern.
3) Remember to include positives.
4) Focus on any point that seems important to parents. Be willing to start at their point of interest. If you support that, perhaps they will support your concern.
5) Don't be afraid to say "I don't know".
6) Assure parents that what you are seeing in their child is a genuine concern (not a threat, diagnosis or label) and that you would like another opinion about your concern.
7) Tell them what you are willing to do and what you would like them to do to seek help about the concern. Be specific. Use the outside resources information.

B. Parents Viewpoint

1) Ask how they see the child at home in the same area of concern.
2) Ask for help from their experience with dealing with the problem.
3) If they ask your opinion about future, say you don't know, but be prepared with specific ideas of where to go for help.
4) If parents are skeptical ask them to observe!
5) If parents are angry or hostile, accept their point of view and ask for an outside opinion to either confirm or dispell your concerns.

C. Together

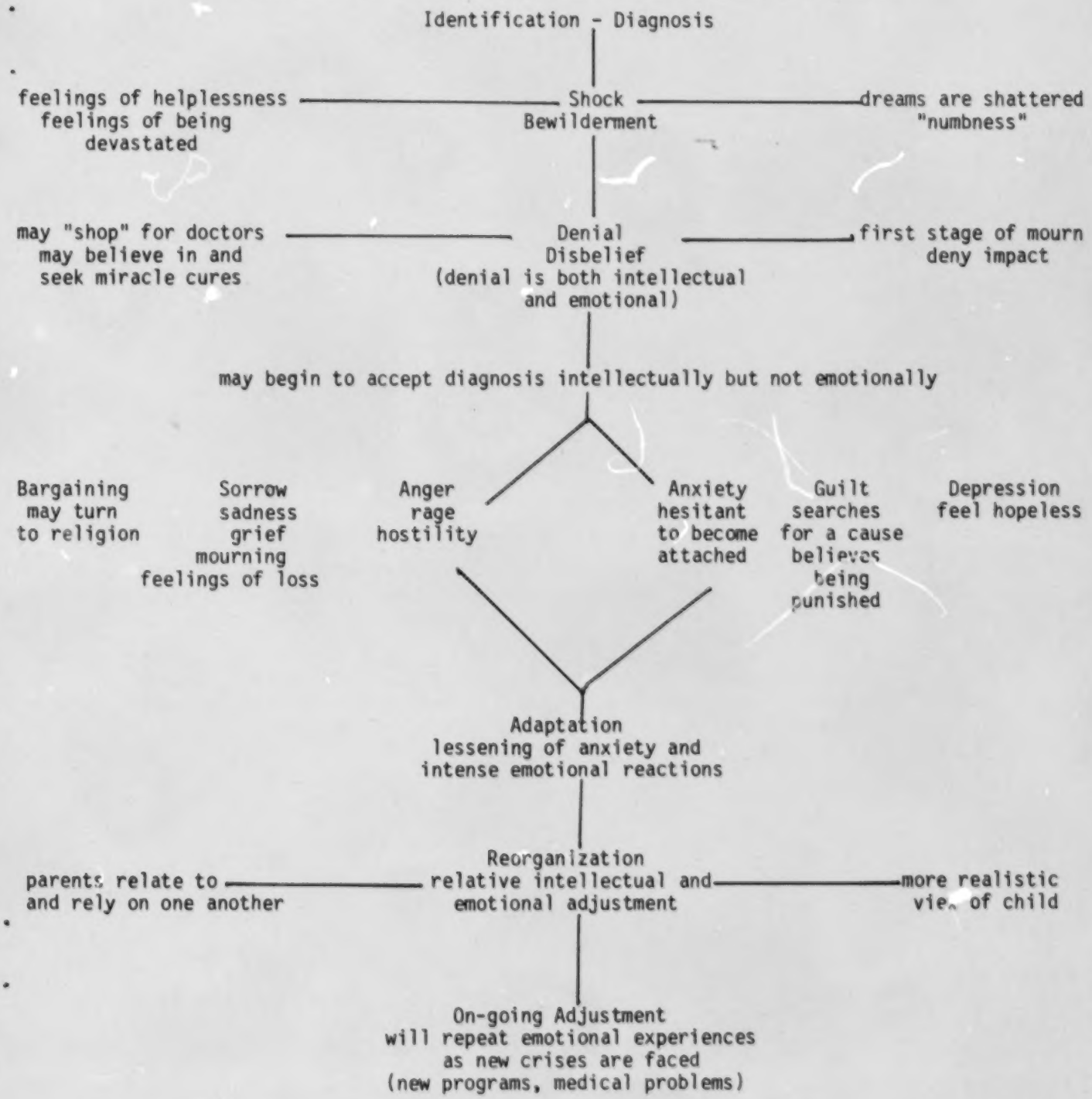
1) Set a direction and course of action for the problem.
2) Focus on one small area to begin with - don't go for a "cure" - there probably isn't one.
3) Always remember the positives.
4) Resolve conflicts with compromise. Two conflicting approaches will only increase the problem for the child (especially behavior).
5) Don't divide into me/them factions. You're approach to the same problem from different angles, and therefore, end goals are common.
6) Admit your own doubts. Reassure parent he's doing a good job (in some area), then own the problem together. You both want what's best for the child.

One final word: Be prepared to lose some clients. Some parents will not choose to or are not prepared to deal with special needs at that point in time. Then it becomes a dollars and cents issue. Can you afford financially, when you consider loss of client, to continue or pursue the battle? It's a judgment you must make. Or, are you prepared to make the decision that the problem is significant enough to be neglect, child abuse? Again it's a decision you must make. Read the enclosed pamphlet on child abuse, go to a workshop, or call and talk to someone at the number listed before you make that decision.

Linda Rees

Project RHISE/Outreach - Children's Development Center
650 North Main Street
Rockford, Illinois 61103

Grieving/Coping Process of Parents of Handicapped Children



Most authorities say that parents never really accept their child's handicap, but continue throughout life to go through the above cycles.

PARENTS

Handout 13B

A WORKING SUMMARY OF THE GRIEF PROCESS

It is now possible to predict fairly well some of the things that will happen to all of us when something or someone very essential to our way of life is severely altered or taken away. The result of such "loss" is always in process--never an isolated event, experience or just a feeling within that is bound by time. And, that process is shared by all members of a family in which a particular event occurs.

Below is a listing of 10 identifiable stages of the grief process. I believe that there is good reason for listing them in the following order, but also be aware that they do not necessarily occur in that order within individuals who are in grief.

STAGE 1 -- STATE OF SHOCK

Each human creature is created with inborn mechanisms that enable one to bear pain and sorrow and even tragedy. However, when the sorrow is overwhelming, we are sometimes anesthetized in response to a tragic experience. We can be grateful for this temporary anesthesia, for it keeps us from having to face this grim reality all at once. This shock stage -- or perhaps it should be called counter shock -- may last anywhere from a few minutes to a few hours to a few days. It if goes on for a few weeks, it probably is unhealthy grief and professional help should be sought.

STAGE 2 -- WE EXPRESS EMOTION

Emotional release comes at about the time it begins to dawn upon us how dreadful the loss is. (I use the word loss because when a family discovers that a member is developmentally disabled, there is a real loss of expectation, hope, etc.) Sometimes without warning, there wells up within us an uncontrollable urge to express our grief, and this is exactly what we ought to do. Both men and women need to be free to cry and to never feel ashamed of the need to emotionally express sorrow.

STAGE 3 -- WE FEEL DEPRESSED AND VERY LONELY

Eventually there comes a feeling of utter depression and isolation. It is as if no one could possibly understand, and we are sure that no one has ever grieved as we are grieving, and that is true because no two persons ever face even the same kind of loss in the same way. What needs to be remembered is that this too is normal and will pass -- the less anxious one is for it to pass is perhaps the better.

STAGE 4 --WE MAY EXPERIENCE PHYSICAL SYMPTOMS OF DISTRESS

Much could be said and written about this. In brief, physical exhaustion is primary when the emotional is manifested through the physical. As stress is felt more greatly, one's physical energy is lessened and resulting symptoms appear -- headaches, backaches, stomach trouble, etc. These usually become considerably less when one begins to feel hope.

Grief stages continued:

STAGE 5 -- WE MAY BECOME PANICKY

We find ourselves becoming panicky because we can think of nothing but the problem, the loss. We try hard to get our minds off the subject, and perhaps for a moment or two we can be distracted from worry, but soon we are right back where we started. Becoming panicky also results from fear, fear of the unkown or fear of something that is so foreign.

STAGE 6 -- WE FEEL A SENSE OF GUILT

We need to immediately make the distinction between "normal" guilt and neurotic guilt. Generally speaking, normal guilt is the guilt we feel when we have done something or have neglected to do monething for which we ought, by the standards of our society, to feel guilty. Neurotic guilt is feeling guilty out of proportion to our own real involvement in the particular problem. The whole subject of guilt is very complex because it is mainly dependent on our environmental input in our lives-one's childhood, religious convictions, social self image, etc. are all factors contributing to one's degree of guilt in a particular situation

STAGE 7 -- WE FEEL HOSTILE AND RESENTFUL

We gradually move from the depression, and in so doing may be more able to express some of the strong feelings of anger and resentment of which we were initially unaware. Too often our society has labeled expressions of these feelings are symptoms uncontrollable personalities, and the church has too often equated anger and resentment with sin. These feelings are normal for us as humans and need to be expressed, not supporessed. If one is shamed for feeling resentful over a disabled child, he will be thrown back into guilt, and will lose benefit of moving through the process.

STAGE 8 -- WE ARE UNABLE TO RETURN TO USUAL ACTIVITIES

No matter how hard we may try, to return to normal activities is very difficult. Part of the problem is that our culture makes it so difficult for us to grieve in the presence of others and, therefore, are forced to carry the grief within ourselves -- particularly true for men. And, many who do respond simply offer sympathy at the moment with the hidden message of "Now let's get back to business as usual again." Again, the idea of grief in process needs to be valued for the total well-being of those who grieve.

STAGE 9 -- GRADUALLY HOPE COMES THROUGH

The glimpse of hope usually comes through the experience of another. And, the hope is, or needs to be, on two levels -- hope for the one who has been directly afflicted that there is help available, and hope for the one who grieves that his/her life need not be totally consumed by the "problem". Nothing is more hopeless than one in grief resigning the self to enslavement of the problem.

Grief stages continued:

STAGE 10 -- WE STRUGGLE TO AFFIRM REALITY

This is not to say that the final stage is when we become our old selves again; that can never completely be. But depending on how we respond to the event and how the process is made available to us will greatly determine if we are either ultimately stronger or weaker from our experience. When one can begin to look back with another and identify the process with a fresh perspective -- then we feel that the primary battle is over.

PARENTS

Handout 13C

As you work with a special needs child, keep in mind these aspects of family life which are affected. Each family will respond differently to having a child with special needs.

1. Marital relationship
2. Parents' behavior toward and interaction with children
3. Siblings' attitude toward and interaction with parents and child
4. Relationships within the family unit
5. Family's interaction with relatives
6. Family's contact with friends
7. Frequence and type of community experience
8. Attitudes of all the people in the family's support system (community, friends, relatives)
9. Family's time schedule and independence
10. Family's "life style" in the home
11. Physical and emotional health of each family member
12. Financial status of family
13. Family's ambitions and hopes for the future.

PARENTS

Handout 13D

I.

When talking to parents about a child we often need to ask questions that may trigger many emotions. Read the following questions and the suggestions for rewording.

1) How early did your child learn to walk, talk, and become toilet trained?

2) Have there been any severe disabilities within the families. retardation, epilipsy, emotional problems?

3) Does your child go to sleep easily for you?

4) Have you or your husband had a college education?

5) What did you do when your child had a temper tantrum, and why?

II. Rewording

1) "When did your child ... is better. The words "how early" may put parents on the defensive if their child's development is delayed. It might be less threatening if this type of question were asked on a questionnaire form that all parents answer.

2) Eliminate the word severe. Substituting medical or learning concerns for the word disabilities would ease the situation. If the parent had dealt with this question on a questionnaire before coming to the interview, she or he might be better prepared to discuss any "touchy" information.

3) Eliminate any reference to "for you". This implies that you are really trying to question the parent's competence. "What are your child's sleeping habits?" is better. When asked in an open-ended manner, it could lead to questions about eating habits, play habits, etc.

4) This again is a question better included in a questionnaire than in an interview. If it is necessary to ask it in an interview, it would be better to ask "How many years of education have you completed?"

5) An open-ended question such as "How does your child handle frustrating situations?" will allow the parent to talk more freely. "What is your reaction?" or "What have you found to be successful in handling his frustration?" will take the threat out of the question while still allowing you to find out information about the parent's management techniques.

III.

Consider the following guidelines when having a conference with a child's parents.

1) Always begin and end the conference with positive comments
2) Be friendly - provide a relaxed atmosphere.
3) Share schedule and routines with parents.
4) Comments should include ways parents can help.
5) Talk about the child's strengths, as well as problem areas.
6) Elicit feedback from parents on their recent impressions of child's behavior and performance.
7) Cooperatively plan ongoing activities and objectives for the individual child.
8) Have parents sign the conference or progress report.
9) Emphasize the normal abilities of a child who is delayed in some other area of development.
10. Don't label the child or overgeneralize about the child's abilities or behavior, for example; "he's <u>always</u> taking other children's toys" or "she <u>never</u> follows directions."

PART XIV
MAKING REFERRALS/COMMUNITY RESOURCES/
LEGAL RESPONSIBLIITIES AND THE LAW

I. Tape

II. Handout 14A - Checklist for Making Referrals

III. Tape

IV. Handout 14B - Screening and Assessment

V. Tape

VI. Handout 14C - PL 94-142

VII. Directory of Resources for Preschoolers

MAKING REFERRALS

Handout 14A

Before suggesting that parents/center directors make a referral, consider the following:

Have you:

_____ 1) Observed the child for a sufficient length of time in order to draw valid conclusions.

_____ 2) Recorded the behavior observed so that it can be shared with others.

_____ 3) Developed some questions to help others identify where help may be needed (eg. Is Tommy hearing?).

_____ 4) Established a good relationship with the parents.

_____ 5) Met with parents to share your concerns with theirs.

_____ 6) Gotten Release of Information Forms signed by parents (so that you may have a copy of the screening or assessment reports).

_____ 7) Gathered information about the agency/school where the referral will be made (i.e. Do they accept insurance, medical assistance clients, base fees on sliding scale)

_____ 8) Planned a parent conference/discussion following the referral/assessment process to discuss your role in helping to meet the child's individual needs.

SCREENING/ASSESSMENT

Handout 14B

Screening	Assessment
Uncovers <u>possible</u> delays in major developmental areas Often includes hearing and vision screening Take 10 - 20 minutes to administer Does <u>not</u> determine if child is eligible for special education services <u>Purpose</u>: TO HELP DETERMINE IF FURTHER ASSESSMENT IS NEEDED.	Done when child fails screening or When other sufficient evidence accumulated to <u>indicate</u> special need may exist. Is a thorough evaluation to determine <u>existence</u> and <u>extent</u> of any developmental delays Covers all major developmental areas. May also include hearing testing, psychological and neurological testing, etc. May last a few hours to a few weeks in an assessment classroom (eg. Mpls Public Schools) <u>Purpose</u>: TO DETERMINE IF AND TO WHAT EXTENT SPECIAL EDUCATION SERVICES ARE NEEDED.

PUBLIC LAW 94-142

Handout 14C

Basic Premise:

Children with significant special needs are entitled to a free, appropriate public education.

a) Whenever possible, these children should be educated with children who are not special needs.

b) They should be educated in the least restrictive (most productive) enviroment.

c) Tests used in assessing a child must not discriminate on the basis of any handicapping condition, race, or cultural background.

d) Educational programming for a child must be a team effort, which includes the parents, professionals, and others as yourself.

e) Testing and educational planning cannot rely on a single test or individual.

f) Observations, medical history and other information must also be included in planning for the special needs child.

g) Aim is to provide for all of a child's needs, both special and normal.

** Child care providers can contribute much information needed through their own observations in working with a special needs child.

ADDITIONAL INFORMATION

1. Head Start - is federally funded child development program primarily for low income children and their families Oct - May 2-3 days a week.

   a) PICA (Parents in Community Action) age 3 - 5

   b) Parent-Child Centers birth - 3

2. Council on Quality Education - CQE

   a) good resource for parenting skills
   b) restricted to residents of each school districts

3. DAC - Developmental Achievement Centers.
   Centers for children who are significantly delayed in two or more developmental areas. They have a variety of services in each geographic area. Usually they serve children birth to 4 years.

4. There are nursery schools and day care centers offering special services.

5. Half Day Treatment Centers
   a) Washburn
   b) Children's Health Center

6. Public Health Nursing Services - is a key resource providing consultation with individual centers at their request about health and developmental issues.

   a) Mpls. - Combined Nursing Services
   b) Bloomington, Richfield and Edina - Bloomington Division of Health.
   c) West & North Suburbs - Suburban Public Health Nursing Services

<u>Other Resources</u>

GMDCA - support service to child care programs in Hennepin County. Providing services in:

a) management assistance
b) Advocates for child care
c) Providing training
d) Providing information and referral to parents

PACER - Advocacy

Pacer Center is a coalition of 18 Minnesota organizations concerned with the education of children with physical, mental, emotional and learning handicaps, and other health impairments.

Pacer provides two programs, parent training and Count Me In, a handicap awareness project. The function of the parent training program is to inform parents of handicapped children of their rights and responsibilities in special education.

SCRIPT FOR AUDIO TAPE

ACCOMPANYING

"CARING FOR SPECIAL CHILDREN"

INTRODUCTION

"Mainstreaming the Special Needs Child: is a ten (10) hour survey course. It is intended for child care providers as an introduction to caring for special needs children in day care settings. Those of you participating in this course will be learning through the use of audio tapes, written materials, and required exercises.

Now please refer to the Course Outline as we begin our discussion.

What is our role as child care providers in regard to children with Special Needs? Why do we need to be concerned? Many of you are either currently caring for or will have an opportunity in the future to work with these young children.

Although some special needs children attend other settings for part of the day, as a preschool/special education classroom in the public schools or receive speech and language therapy, they may need day care for the remainder of the day. Their parents are often unable to find caregivers who are willing or able to take their children.

You, as a child care provider, therefore, can provide a very important and essential service to these families. It is hoped that by completing this course, you will feel better prepared to care for special needs children. We hope you will be encouraged to learn more about this topic through future workshops and classes.

PART I

"MAINSTREAMING"

What is Mainstreaming?

Mainstreaming means including children with special needs into regular group settings - such as day care centers, family day care homes, and nursery schools - with other children who are developing at age level.

Why Mainsteam?

By mainstreaming special needs children, we are providing them with a normal group learning experience. It is hoped that in a nurturing setting, they will be stimulated to develop to their full potential.

It is important to realize, however, that a special needs child will require more help. Simply placing a special needs child into a normal child care setting does not guarantee that individual needs will be met. The child care provider needs to carefully observe the special needs children and learn about the areas in which they will need extra help. We need to be careful not to forget that these children have many of the same developmental needs as the others in our care. They are first and foremost children, who need our support, encouragement, and acceptance- Mainstreaming is beneficial for some, but not all children. Decisions need to be made based on each child.

There are several points that one must consider when deciding whether mainstreaming will be appropriate for a particular child. Please refer to the Mainstreaming handout 1A to help you complete activity 1B. Also read Handout 1C, "Encouraging Positive Interactions".

PART II

SPECIAL NEEDS CHILDREN

Please refer to Handout 2A as we continue our discussion.

In this section two questions are addressed:

- Who are Special Needs Children? How do they look and act?

Special needs children perform below what is normally expected of children their age. Sometimes we know the reasons or causes for this, but often we do not. They will have a mild to severe delay in one or more area of development. For example, a three year old's speech may be very difficult to understand and may sound more like a child of two.

Special needs children frequently show no visible sign of their delay. Often, at first glance they seem no different from others their age. It is only when we observe their behavior more closely that differences may appear.

Like all children, those with special needs have many areas of strength. For example, a child delayed in motor development may have age appropriate speech and language skills. We need to be aware of children's strengths, as well as their areas of need.

With appropriate help some special needs children can catch up by the time they reach kindergarten. Others will continue to need some type of special help.

It cannot be assumed that these children will catch up on their own. It has been shown through years of research and experience that good quality care, even beginning at infancy, can help prevent or lesson developmental difficulties. Children have shown much growth and improvement as a result of receiving appropriate early education. Others have lost ground and have entered kindergarten even more delayed because an appropriate program was not available.

Special needs children need, as do all children, stimulation, direction, and activities which are developmentally appropriate. These will affect later learning and emotional development.

*NOW - please complete Special Needs Activities, 2B and 2C.

PART III

DEVELOPMENTAL DELAY

The majority of special needs children you will encounter in child care settings will be "developmentally delayed". These are children who have a significant delay in one or more area of development. The cause for this delay may be unknown.

But what is considered to be "significant"? Generally, a 25% delay - that is 25% of the child's age - is considered significant. For example, a four year old who has the motor skills of a three year old would have a 25%, or one year delay. A child of three with a nine month delay would have an equally significant delay - with nine months being 25% of the child's age, three.

It is also important to keep in mind the difference between how old a child actually is and the child's skill level. The skill level is referred to as a child's Developmental Age. Skill levels may vary in different developmental areas. We begin to teach children at their developmental level. Remember - a child's real age and developmental age are not necessarily the same in all areas.

There are a few more points we would like to make regarding development.

First of all, in order to understand what the special needs of children are, one needs to have a solid background in Normal Development. Handout 3A, "Developmental Milestones", Birth to 5, will help you in reviewing this information.

Secondly, all children, including those with special needs, follow a predictable sequence of normal developmental. However, children build skills one step at a time. Each child learns at a different rate, some learn much slower than others. Therefore, we cannot expect a four year old who has three year old speech and language skills to acquire four year old skills before learning those between

three and four. We need to be aware of how skills build on each other to help children grow.

Lastly, it is quite common for a delay in one area to affect a child's development in another area.

For example, a four year old who has difficulty understanding or following directions in an activity (with possible delays in language) may also have difficulty playing a game with a group of children (a social skill) because he is never quite sure of what to do next. It is important to closely observe a child to find out what other problems may be causing particular behavior.

Now please complete Activities 3B and 3C then please read Handout 3D, A Developmental Questionnaire.

PART IV

SPEECH AND LANGUAGE

Now we will begin our discussion of the various areas of developmental delay.

Please review the handout 4A on Speech and Language definitions before beginning this section.

Now some general points about language:

Language learning is all the time. Language Development can be stimulated thoughout the preschool day.

By five years of age, children have learned all the basics of language development, for instance, sentence stucture, word order, and rules. From five years on, children continue to refine the skills they've learned.

Children learn language skills at different rates of development. However, the sequence of language development is the same for all children (special needs or not). Children must master the skills required at earlier ages, before they can be expected to accomplish later developmental skills.

Children may have a developmental delay in one or more of the following areas of speech/language development. Receptive Language, Expressive Language, and Articulation.

Generally, Receptive Language preceeds the development of Expressive Language skills. However, just because a child uses a word does not mean that she understands it.

Articulation is the term used to describe the production of speech sounds. It refers to children's expression of meaningful language. Good articulation skills become most important when children are trying to communicate real, meaningful

language. Good articulation skills become most important when children are trying to communicate real, meaningful words - as when they want to tell us about something or ask us for something.

Much frustration results when children have the language, but not the articulation skills to express themselves and cannot be understood by others...
(Brief Pause)
And now a few words about CHRONIC EAR INFECTIONS.

Chronic ear infections are common in preschool children. It is important to pay close attention to those children who seem to have frequent colds and ear infections. Often doctors prescribe antibiotics, such as penicillin, to help children fight this infection. However, penicillin does not always solve the problem. When fluid has also accumulated inside the ear during an infection, it may remain for up to 3 to 6 months. During this time, the children have temporary hearing losses. What they hear may often seem unclear, muffled, or very soft. Also, speech and language skills may become delayed, since the children are not hearing normal speech models.

If this condition reoccurs again and again - a permanent hearing loss can result.

An alternative treatment is for the doctor to place small tubes into the ear to drain the fluid out more quickly and thus lessen the chances of this problem reoccuring -
(PAUSE)
There are several simple techniques that can be used to help stimulate and promote growth of speech and language skills in preschool children.

Please review the following techniques on handout 4F as each is defined and an example is given.

SPECIFIC SPEECH AND LANGUAGE STIMULATION TECHNIQUES

MODELING

In modeling, the adult provides a verbal example for the child to imitate. For very young children modeling would be simply providing labels for objects, people, and actions in their environment such as: Mommy, bottle, potty, puppy, ball, etc. As the child's language becomes more complex, so does modeling by putting words together to communicate meaningfully: for example, bottle all gone, go potty, puppy is barking. We model complete sentences for older children such as "tie my shoe, I want juice, It's my turn."

SELF_TALKING

When self-talking, the adult describes an activity while performing it in front of the child. Talk out loud about what you are hearing, seeing, doing or feeling whenever the child is nearby. Repeat important words and phrases several times. In this way we provide children with language models they will later express on their own. For example: while the child is watching you make a cake you might say "Look _____, I'm pouring in the flour and some water, now I'm stirring the cake."

PARALLEL TALKING

When parallel talking, the adult describes to the child what that child is doing, seeing, feeling or hearing at the moment or what he has just done. It is a way to give words to a child who has minimal expressive skills. For example: while watching a child build with blocks say "you are building a little road for the little cars." "Now you're making it longer." You can also follow your statement with a question. For instance while watching the child building you might say "Oh, the bridge fell down." "What happened to the bridge?" and the child might then say "The bridge fell down."

QUESTION ASKING

In question asking, the adult needs to ask questions so that the child will be able to understand and respond to them. There are two types of questions.

Close ended questions, which require the child to respond with a "yes" or "no" answer. For example: "Do you want a cookie." and Open ended questions, in which the child is required to respond in several words add, "What do you want?"

Open ended questions stimulate the greatest language expression from the child as opposed to "yes" or "no" type questions.

Using questions and phrases such as "What is happening?" "What do you want?" "What is he doing?", and "Tell me more about it", encourage the child to talk.

EXPANSION

When using expansion, the adult adds to what the child has said. Expansion provides additional information to children. It is especially important when used with children delayed in expressive language skills. Here are some examples of expansion: a child might say "That's hot!" You'll respond "Yes, the stove is hot", "Mommy's coffee is hot, too."

You can also stimulate the child to attempt to expand her own language by saying "Say the whole thing." You can add new information to what the child says. For example: child says "I like grape juice." and you say "yes, and sometimes we have orange juice instead of grape juice."

Another use of expansion is to correct a child's error. Instead of telling the child, "You said it wrong", you can repeat the child's statement with corrections. For example, the child says "Me want cookie." and you respond "Yes, I want a cookie too."

PROMPTING

When prompting, the adult gives the child a verbal or non-verbal cue to help the child respond. Prompting may involve pointing, pausing, or beginning a word or phrase to help the child respond. For example, when pointing at a picture say "This is a _____", leaving off the end of a sentence for the child to finish.

Now complete Activity 4G.

PART V

COGNITIVE DEVELOPMENT

Cognitive Development is the process of thinking, of perceiving, of solving problems, of understanding how the world works. It involves the ability to make comparisons between things, to see the relationships between things. The ability to generalize, to categorize and to make correct associations between ideas and objects - these are all aspects of cognitive development.

It is also a twofold process which involves both physical development and the child's use of materials. As we discuss cognitive development we will be using ideas and terms which were first introduced by Swiss psychologist Jean Piaget. We would like to share just a little of Piaget's background with you.

> In 1920 when Piaget was 24 years old he went to work in Paris to help develop standardized reasoning tests. He became very interested in the incorrect answers children gave on these tests and began looking for patterns in these answers. Piaget concluded that young children think differently from older children and adults. He studied this development until his death just a couple of years ago. In this course we will refer to some of Piaget's general ideas. If you are interested in more detail please refer to your bibliography. Refer to handout 5A during the following discussion.

The period of cognitive development up to age two is called sensori-motor. This means that the child learns by directly handling, touching, and moving objects or physically moving around. In this sensori-motor period the child learns some of the basic ideas that are necessary for problem solving and for learning language. These skills include learning that objects exist apart from oneself, that objects are different from one another, and that objects have

permanence, that is, a child can find an object that has been covered or hidden. The child also learns about cause and effect relationships. For example, if she pulls the string attached to the train, the train will come to her. This is a major developmental accomplishment by the age of two. The child can imagine objects and actions before they occur and can remember them after they occur. A normal two year old knows what a chair is if you say the word to her, without having to see one. This new ability comes after much experimentation and discovery. It is at this point that children can develop and use memory, language and make-believe.

The term preoperational has been used to describe the period of childhood from ages two to about six when children think in concrete terms. For example, a three or four year old who sees butter melting in a pan may say that the butter is running. You may ask "does that mean the butter is alive?" The child answers "Yes! it's alive" "Why is it alive?" "It moves". This is the type of thinking that providers will observe in their preschool children.

From ages two to six, then, the child responds to the physical appearance of things. She sees things as they are, in a final state. A classic example, and one of Piaget's experiments, involves water in cups. Say we have two cups of the same size with equal amounts of water. The child will agree they are the same. Now we pour the water from one of the cups into a taller, narrower container. If we ask the child which is more, she will likely respond the taller cup has more. When we then pour the water back to the original cup the child will again agree that now they are the same.

Preschoolers do think differently than adults and we must take into account how they use language and reason and how they perceive the world.

As the child's intellect grows through interaction with her world- both objects and people- more and more mental associations are made. As the child physically acts on these associations further cognitive development occurs.

In your packet is a handout on Development Milestones which lists some of the cognitive skills preschool children have. There is also information about when to be concerned about a child's cognitive development as well as some possible reasons for why a child may be cognitively delayed. Please review handout 3A and read handouts 5B and 5C .

What about the child who cannot do typical preschool activities. How can providers help? Let's take the example of pasting together parts of a face- an activity a certain child is finding difficult. First of all it is important not to rush in and do it for the child. We can give the child time to experiment, to look at the model, help her think about where the eyes go in a face. We can give verbal suggestions. If the child cannot use that information we can show her where our eyes are, where the eyes are on the model. If the child is unable to imitate at this point, we can physically assist her, saying "I can help you. They go right here." Sometimes the tendency is to rush right in, but what we want to do in working with children who are cognitively delayed is to allow them as much opportunity to experiment as we do normal children. At the same time we need to assist when it is necessary in order to give the child the experience she can't quite give herself.

Playing, exploring and experimenting are very important for preschool children. Through play a child rehearses behaviors, learns new skills and refines what she has already learned. A child takes in the encouragement, discouragement, and frustration from the adults around him- parents, and providers. In our

relationships with special needs children, we want to be very aware of how we talk to children.

Now complete activities 5D and 5E .

PART VI

MOTOR DEVELOPMENT

Before listening to this section, please read handout 6A so that you are familiar with the terms we will be using. The terms are quite technical so keep the definitions close by.

Also, your developmental milestones handout 3A and handout 6B include the basics of motor development. When you are familiar with normal development, you will be able to pick out what is abnormal or what may be a problem. This is something that providers are constantly learning.

Motor Development is divided into two general categories - fine motor and gross motor. Fine motor refers to the use of one's hands and fingers. Gross motor refers to the use of the whole body and ways of moving. It is also referred to as large muscle development.

Motor skills develop from larger, more gross movements toward smaller, finer movements. For example, at first an infant will wave her arms around randomly. Soon she can hit at a mobile. Then she will reach for an object. As she becomes more skilled she can explore an object with her hands. In other words, her actions become more refined.

We will briefly discuss ways that children receive information about their world through their bodies. Through touch, or tactile sensation, children learn a great deal. Many activities in the day care home or center can provide this experience, such as water play, fingerpainting or sand play.

A sensation or experience which affects a person's sense of balance is called vestibular input. The nerves which sense vestibular input are in the inner

ear. They are affected by a person's moving side to side or turning around. Activities which provide these sensations include rolling, swinging, jumping or any type of movement where the body is moving through space.

We also receive information or sensations from our muscles, tendons, bones, and joints. This is called proprioceptive input, and is seen in weight-bearing positions such as wheel barrow walking, crawling on all fours, jumping, hanging, pushing and pulling. Once we know how to do these things we can just do them without having to deliberately think about them.

Kinesthesia is a more conscious awareness of one's body position and movement. An example of this would be if you were blindfolded and somebody moved your arm, let's say above your head. Even without seeing it you would know it was above your head. That's because of your sense of kinesthesia- you know where your body position is without having to see it.

We'd like to emphasize three points. First of all, the quality of a child's movement is more important than the child's developmental level. Are the child's movements rigid? Is the child generally uncomfortable with his body? Does he fall down a lot or appear fearful? Remember, it is important to look at <u>how</u> a child does something as well as to look at what he does. . .

The second point is that children do not continue in a motor behavior, unless they are getting something out of it. It is the adults responsibility to guide children's movements appropriately. Sometimes you will see children engaging in an activity or behavior that is not appropriate. It may be socially inappropriate or hurtful to the child. For instance, children who are always running into things may be having difficulty understanding where their body parts are in relation to other objects.

The third point is that children are the best judges of what they need and of when they have had enough. Adults cannot possibly know everything that is going on inside a child and they need to respect children's responses. It is important for providers to offer activities in which children can control the movement. Never impose activities, such as spinning, on a child.

And one final point. Sometimes children who seem to have a behavior problem are really experiencing some delay in motor development. When they receive appropriate help, you will usually also see a change in behavior.

Handouts 6D & 6C contain information about activities and some problem areas in motor development that providers are most likely to see. Please review the information at this time.

Then complete Activity 6E .

(PAUSE)

Before we end this section on motor development we want to talk a little about seizures. Please refer to handout 6F .

While seizure disorders may not be common in the children you see, it is still important to be aware of them. Sometimes these children exhibit behaviors which seem inappropriate and it is important to consider the possibility of seizures rather than react as if a child is just acting silly or naughty.

You might see a brief motor seizure. This might involve a muscle jerk, blinking, or a rapid fluttering of the eyes. The child is trying to attend to a story or activity but phases out briefly. Brief periods of staring may be another indication. Some children don't appear to really be having a seizure. A child may sit down at the table to do an activity and promptly fall off his chair, then

seems fine afterwards. This child may be having some small motor seizure. Be concerned if this is happening consistently or frequently.

Children may be drawing and have a seizure. The child may ruin her own drawing but be appalled that "someone" wrecked her paper. She may be unaware that she did it herself. Also be concerned if you have a child who is generally quite skilled in motor activities but who begins falling a lot, seemingly over nothing. Children having these types of mild seizures may or may not seem confused following a seizure. Just a reminder - If you are seeing these kinds of behavior it is important to report them to the parents. Keep track of how often these behaviors occur, what time of day they occur, how long they last, what the behavior is - falling, staring, etc., and how the child behaves afterward.

Sometimes children are given medication for seizures. The children and the seizure activity are affected differently by the various medications. If you have a child with a diagnosed seizure disorder, be sure to inform parents of any seizure activity you observe. It is common for a child just starting a medication to be sleepy or less active or alert. Once the medication is at the proper level this should not continue.

Also do not spin a child who has a diagnosed or suspected seizure disorder - as it is possible to bring on a seizure.

PART VII

SOCIAL AND EMOTIONAL DEVELOPMENT

At times dealing with children who have delays or difficulties in this area can be tricky. This is because our own emotions play a role, especially when we become frustrated or angry with a child. We may be uncertain as to what approach to take. Sometimes it is difficult to determine whether a child is delayed in this area. For example, while aggressive children are usually easy to identify, passive children are harder to notice and they can get overlooked within a busy group of children.

There are also many differences among people as to what is acceptable behavior. What may seem inappropriate to one caregiver or parent may be acceptable to another. An example would be an active two or three year old tearing around the house. Some adults may view this as intolerable while others may smile at his energy and enthusiasm.

It is important to realize and helpful to remember that there is a sequence in emotional development, just as in all the other areas.

Children experience many different emotions, just as adults do. Children do need to learn how to label their feelings and express their emotions. What are some of these emotions?

Anger is one that parents and providers deal with frequently. Some other emotion often leads to expressions of anger. A child who is hitting or striking out angrily is often experiencing some other feelings as well. She may be tired, frustrated, embarrased or afraid. It is helpful then to reduce frustrating situations as much as possible. This may mean putting away or rearranging certain objects.

Hitting, biting, pinching, poking, throwing toys- these are all clear expressions of anger. Teasing or tattling, on the other hand, can be indirect ways of expressing anger.

Fearfulness is common in young children. Fears can develop through associations with such things as doctors, dogs or storms.

Some fears are related to the child's developmental level. For example, infants are often fearful of loud noises or unfamiliar people while toddlers may be afraid of falling, and preschoolers may worry about imaginary creatures, the threat of danger or of being alone in the dark. Whatever fears children are experiencing it is important for adults to offer their support and understanding. By respecting children's fears, by providing experiences to play or talk about them, providers can often help diminish or even alleviate them.

Jealousy is another emotion children exhibit. This is often expressed as sibling rivalry as children come to realize they must share their parents' love and attention. Sometimes children will feel the same way about their providers. This can be expressed through aggression, by striking out at others. It can also be expressed through regression- going back to earlier forms of behavior such as wanting a bottle, using baby talk, wetting pants and so on.

Young children also experience anxiety. This is a response to some danger or fear which can be real or imagined. For example, children may become anxious when their parents leave them at the day care center or family day care home. Children can show their anxiety in different ways. One may cry, another sit passively and suck his thumb and a third may immediately become intensly involved in some activity.

In summing up this discussion we want to emphasize that children experience and express a wide range of emotions. It is the adults' responsibility to help children accept their feelings and to help them learn to express their emotions effectively.

At this time please do Activity 7A .
(PAUSE)

There are many reasons why a child might be socially and emotionally delayed. A child's first relationships are extremely important in forming the base of her self-concept. For example, disturbing experiences in the family and environment can affect these relationships and can affect emotional development. Divorce, separation, hospitalization of the child or parent and birth of siblings can all influence the child and family. As providers we can help the child by reflecting about what is going on and by encouraging certain kinds of play in which the child can freely and safely express feelings.

In your packet is some information from Washburn Child Guidance Center titled "Signs of High Risk in the Preschool Child", Handout 7B. Please read it over. What we want to emphasize here is that in looking at social and emotional development no one behavior can tell us whether a child is having problems. Behavior can be typical for one age but not for another. For example, we expect a two year old to grab toys he wants even from another child. We are not concerned. However we do not expect a four year old to act this same way. There are some patterns of behavior which do require our attention. Some of these are included in the Washburn handout.

What can providers do to help children feel good about themselves? There are at least two answers to that question. One is to provide as many experiences as

possible in which children can succeed. This builds confidence, positive feelings about themselves and a willingness to try more new things. The second answer is to let children know that they are valued for themselves. Focusing on their positive, individual strengths, praising whatever progress they make, helping others to think positively about children- these benefit all children, special needs or not. A provider's expectations for the children are very powerful and are communicated both verbally and non-verbally. In fact, children often attend to body language more than to what adults say with words. It is important not to give mixed messages to children by saying one thing but doing another.

There are some techniques which will help you in working with children who are socially or emotionally delayed. With any technique it is important to know why it is being used and to concentrate on those with which you feel comfortable and sincere. Children are very good at picking up ambiguity on our part and it will only confuse them.

At this time please read handouts 7C and 7D. Complete activity 7E.

PART VIII

LOW-INCIDENCE HANDICAPS

So far we have been discussing developmental delays in children. Another special needs area to become aware of is Low Incidence Handicaps.

Low Incidence Handicaps are conditions which can often be diagnosed medically. Their causes may be more easily determined than a developmental delay. These handicapping conditions range from mild to severe. Although children with low-incidence handicaps often receive special education services in some form, they may also be mainstreamed in day care settings for at least a portion of the day. Therefore, it is important for you to learn about some of the most common handicapping conditions. Please review handouts 8A and 8B.

PART IX

OBSERVATION AND RECORDING OF CHILDREN'S BEHAVIOR

Please refer to Handout 9A during this discussion.

What is observation? Don't we as child care providers observe all of the time in one form or another? Isn't it just the natural thing to do when you're around children?

Yes, watching the behavior of young children is a most common thing to do in day care settings. Yet, observation is a skill that we can develop over time. It is a skill in which we learn to sensitize ourselves to a child's behavior cues. When observing, we need to take on the children's perspective in trying to understand what they are doing, what their behavior means, or what they may be thinking and feeling. It means watching the skills they present during a group time, watching how they react to their parents coming and going and so on.

There are several reasons for closely observing and recording behavior. First, observing in an organized fashion can add invaluable information to what has already been gained from formal testing by a psychologist or speech/language clinician, for instance. Child care providers have a unique opportunity over time to gather information in addition to that gained by a professional in one sitting. This perspective should not be underestimated.

Secondly, we can gain useful information from recording notes about a child's current developmental skills and from this, will be able to more effectively plan appropriate goals and activities for a child, especially for one who may have special needs.

Information that we gather is also important to share with parents, especially in

indicating to parents what they can watch for at home. So when there is an area of concern, you can both work together in order to best help the child.

Lastly, observing and recording the situations which seem to set a child off and cause a problem behavior can be most helpful.

We need to look for what was happening before a tantrum, for example, and keep note of how we reacted and what the results were. Often, over time, patterns of behaviors, causes, and solutions arise and from this we can learn how to prevent some outbursts altogether.

Anyone coming in contact with children can contribute valuabe information- to the observation.

The skill of observing comes from being able to pinpoint the exact things you are looking for. We need to look for directly observable behaviors. In other words, any observable action or activity that a child does. Be sure to distinguish between your feelings and the child's actions. You need to clearly define the behaviors that you want to look at so that anyone else observing the child would be noting the same behaviors as you. For example, you may wish to help a child learn how to lessen his aggressive behavior. But first you will need to see if there are any patterns in this child's behavior to help you decide how best to go about solving the problem.

But what is this "aggressive behavior" you're looking for? Is it hitting, kicking, biting, or yelling that's causing the problem? You need to decide exactly what behaviors you're looking for before beginning. If you only told someone to watch for "aggressive behavior" without defining it, they might end up recording information completely different than yours.

Also, be sure to observe not only what children are doing, but how they are doing it. For instance, if you are observing how a child uses his body, you might just ask- Does he move smoothly, or are his movements somewhat jerky, etc.

The best time to observe depends on the situation and the information you are trying to get. Observing and recording can be done daily, weekly, whatever suits your purposes. Maybe a certain time of day or during a particular activitiy would be most helpful to you.

Where you should observe depends on what you're looking for. It can be inside, outside, upstairs, or down. For example, if you want some specific example of a child's language you may find it helpful to keep a small notebook in your pocket to jot down a sentence or phrase whenever, wherever you hear it. A blackboard or large piece of paper on the wall can serve the same purpose.

For recording ovservations - Paper and pencil, in whatever size and shape is most convenient, is all thats needed, some find that a clip board is helpful and provide a simple and efficient way to record information. Whatever you use, though, make sure to include the date of the observation, the child's name, age, time of day and the setting.

To sum up. When observing and recording, decide what your purpose is. Is there a problem you're trying to understand or some question you want to answer? Distinguish between subjective feelings and your objective observations. Before drawing any conclusions, make sure you have accumulated enough information to back them up. Conclusions cannot be made from one incident. Look for patterns and behaviors that recur over time. The strength of your conclusions depends

upon how carefully you have observed.

Please review Observation handout 9B. Following this review, complete Activity 9C.

We've also included a few examples of observation forms for you to review- we hope you'll find these helpful.

PART X

GOAL SETTING

It is important to learn how to set appropriate goals for the special needs child, as well as for all children in your care.

There are two types of goals.

Long range goals are broad, general goals which can cover a period of weeks or months. Examples would include: improving parent involvement, increasing a child's use of social speech and so on. Out of long-range goals come short-term goals. These are much more specific and are worked on daily or weekly. A short-term goal for a group might be to introduce the color red for the week. For an individual child, it might be for him to stay at group time until the story is finished. It is important for you to state goals or objectives in terms of skills and behaviors that need to be learned and that can be observed. Also, set a target date for when you hope this objective will be accomplished. New objectives are developed as needed.

Please refer to handout 10A to review some specific information on writing goals.
(Pause)

There are several things you need to consider when setting goals and planning activities. Please refer to handout 10B, Goal Setting, as we highlight a few points.

First, transitions.

Transitions, or how children move from one activity to another, are very important. Sometimes we become so involved in one activity or another that moving children

from one area to the next can become quite chaotic. Some children need to be walked through transitions if they are unable to manage on their own.

It is very helpful to think through daily transitions and to plan for them. For example, do you want all the children to go through a transition at the same time? Do all the children know what they are supposed to be doing?

Transitions, too, can become an activity in and of themselves. Times when you have to wait can be filled with songs and finger plays to make the waiting easier for the children and you.

Finally, we'd like to discuss how you can meet the individual needs of a special needs child or any child within a group- in order to do this, you need to know each child's skill level in your group. For example, many of you have probably done flannel board activities. Let's say you have a child who is not very verbal, as well as others who are quite verbal. If all your questions require a verbal response, the non-verbal child is not likely to participate. You can vary the questions so that both verbal and non-verbal responses can be made. For example, you might ask the non-verbal child to point to something or to put an object on the board. In this way, you can expand the language skills of all the children, while also providing ways for the less verbal child to feel successful and a part of the group.

Now please read handout 10C.

Then complete three out of the five activities provided in 10D through 10H.

PART XI

TASK ANALYSIS

Task Analysis refers to breaking down a specific long-term goal or skill that a child needs to learn, into several smaller steps. Each step will be more difficult than the last. The purpose of task analyzing is to teach children new skills, one step at a time, so that they will feel successful along the way.

If we try to teach a child tasks which may be too difficult, without considering those skills which must come before, both we and the child will continue to be frustrated and unsuccessful.

There are several things we need to remember when choosing to task analyze.

First, make sure to set goals for children based upon their developmental skill level in a particular area, not only on their age. Also, consider the rate in which children learn.

Second, make sure that you structure tasks and activities which are also based upon the developmental level of the child. Introduce new tasks in a familiar setting, using objects the child already has had experience with.

Third, before presenting a task, think about what pre-skills a child will need to be successful. For example, a child needs to be able to grasp objects with her thumb and forefingers and scribble with a crayon before she will be able to cut with a scissor appropriately.

Finally, it is important to think about what kinds of assistance a child might need in order to be successful at each step.

A child may need physical assistance. For example, you may need to guide a child's hand while he is cutting or physically move him through an activity.

Perhaps, the child will need visual assistance. For example, when teaching the child how to draw a square, you may first need to draw dashes for the child to trace.

Verbal assistance, in which you may help "talk" a child through an activity or give him additional verbal directions for each step along the way, may also be necessary.

Another teaching method is called "backward chaining". This is when you teach the last step of a task first. For example, if an entire puzzle is too difficult, leave out only a few of the pieces for the child to complete successfully.

Now please, read handouts 11A and 11B. Then complete Task Analysis Activity 11C.

PART XII

ENVIRONMENT

We will briefly discuss the environment in the family day care home or day care center. We use the term environment to include:

- The ratio of adults to children
- The routines, schedules and transitions that are followed during the day
- The length or time of day children are in the day care home or center
- The arrangement of the physical space.
- The toys and other materials and how they are arranged

The ways in which homes, centers and play yards are set up can result in certain kinds of behaviors and expectations. This applies to both children and adults.

When evaluating the environment, it is important to keep in mind both individual and group goals. Ask yourself what is happening in a certain area of your home or center. Is that what you want to see happening? Or another question. Perhaps you have noticed that your group of children has a difficult time with certain activities or transitions. Is there something about the environment which is contributing to that? Once you begin looking your answers may surprise you.

Please read the two examples in your packet. 12A and 12B.

It is important to remember that evaluating the environment is an on-going process just like observing children or setting goals. As children grow and change or as special needs children join a group, the demands on the environment also change. Studies have shown that the clearer the group and individual goals, the easier it is to evaluate the environment.

Please refer to handouts 12C, 12D, and 12E for more information and ideas.

then do activity 12F.

PART XIII

WORKING WITH PARENTS

As we discuss the topic of parent cooperation, the first thing to be aware of is the difference between the ideal and the real, between what we would like to have as parental involvement and what is realistic given the provider's time and the parent's accessability. Often there is a gap. Parents differ in the level of their involvement. Sometimes how we approach them can make a difference, but in other cases, parents may become very defensive when a provider is concerned about their child. Sometimes you encounter parents who are extremely depressed or who have so many problems of their own that they are really unable to provide you with much support in working with their child.

When you work with a special needs child it is important to have frequent contact with the parents, either in person or over the phone. Most parents have information about their children which can be helpful to you in your work at the center or in your home. As providers you may have information and suggestions for the parents. For example, some techniques to stimulate language. It can be difficult to make contact with parents in centers whre there is no regular conference time or little parent involvement in general. As providers you are blazing a trail for this involvement. It is much easier to talk to a parent about a concern when you already have a rapport with them. It is still difficult, though, to tell parents that you have concerns about the rate of their child's development or some aspect of that development. Parents don't want something to be wrong with their child. It is difficult to hear your concerns even though they may, and often do, suspect that something is wrong. A parent's first reaction may be to blame you or become angry or defensive. For example, if you are concerned about the child's hearing and ask the parents about it and if they've noticed anything, they may say No. If you pursue this

and ask whether the child's hearing has been tested, or could they make an appointment for this because you are really concerned, the parent may then take the child to the doctor. Be sure to give examples to illustrate your point. What sometimes happens, though, is that if the parents get the test results and don't like them, they may try to find another doctor in the hopes of obtaining different, more favorable, results. Keep in mind, however, that it can be helpful and wise to get a second opinion. And it's important to distinguish this from doctor-hopping.

At this time please read articles 13A, 13B and 13C.

Also in your packet is handout 13D which lists a number of points to keep in mind when talking to parents about their children.

There is another issue that comes up when you work with special needs children, and that is from parents whose children are not developmentally delayed. Sometimes they are concerned because there are special needs children in your home or center. Parents may not know what the special needs are or what may have caused them. They may wonder and worry about whether their child can "catch" some problem. Parents may also express concern that their child will start behaving like the special needs child or they may feel that too much of your time and attention is focused on the child with special needs. These are all legitimate concerns and they need your attention. Talking with parents calmly, explaining the situation clearly, assuring them of your interest in and involvement with their child and keeping them up to date on their own child's growth and progress will usually go a long way toward decreasing parent's anxieties. It can be helpful, too, to point out the ways in which individual children and the group have benefitted from having special needs children among them. Try to emphasize the positive.

Parents can feel inadequate as they listen to the caregiver talk about their child. The caregiver has daily observations, but the parent has the special needs child. We need to consider how to bridge the gap.

It is part of our role as caregivers to try and put ourselves in the parents position. Sometimes barriers are set up unintentionally. The lines of communication really must be kept open and that involves being available to parents, being respectful of them and keeping discussions focused on the child. Share your information freely, clearly, and frequently and remember it takes time and effort for parents to accept that their child has some special needs.

Lets consider another side of that? A parent who really does not want to take the child to the doctor or audiologist to have his hearing tested. Who do we put first - the parents' feelings or the child?

Another role we have as caregivers is to advocate for the child. Sometimes we need to gently but persistently keep parents aware of our concerns. Maybe we can help them take the first step by providing them with names and phone numbers, or be there when they make the call. At times a teacher or provider has gone with a parent to the child's assessment.

Sometimes a caregiver mentions a concern to a parent but the parent has not made that same observation. The parent adds that the child was just at the doctor and the doctor did not express any concerns either. Then what?

It's quite possible that the doctor did not make the same observation for any number of reasons. Perhaps the visit was very short or for some very specific reason or because of the circumstances, the behavior you're concerned about did not occur. The parent may feel you are mistaken. After all, if there was something wrong, the parents may feel that the doctor would have said something.

Continue talking with the parents. Point out the observations you have made. Again while being sensitive to the parents, you are acting as an advocate for the child.

PART XIV

REFERRALS AND LEGAL RESPONSIBILITIES

What is the role of child care providers in referring special needs children for further help?

Child care providers serve as an important link in helping to find the best service for special needs preschoolers. You may often be the first one to notice a child's potential difficulties or may be the additional supprt parents need to encourage them to seek out help for their child.

Please handout 14A, which is - checklist to help you in making referrals.

A child's potential is determined through the process of screening. The purpose is to uncover possible delays. A screening lasts perhaps 10 to 20 minutes. Screening is not the basis on which to determine special education services. It is only a first step. If and when a child fails a screening, then a referral is made to assess the child. Assessment is a thorough evaluation to determine the existence and extent of any developmental delays. An assessment considers the major areas of development. It may also include such areas as hearing, psychological or neurological - whatever is necessary for an accurate and fair evaluation. The purpose is to determine if and to what extent special services are needed and in what areas. Please refer to handout 14B.

There are some important facts you need to be aware of in regard to special needs children and the law.

The services now available to special needs children are largely the result of a federal law. In 1975, President Ford signed Public Law 94-142 (ninety-four one forty-two), called "The Education for All Handicapped Children Act." It is now commonly referred to as PL94-142. Certain state laws also address

the education of special needs children. Minnesota has been serving some special needs children since 1957. However, as of 1977, the Minnesota State Legislature mandated that school districts provide educational services to all children with significant special needs, ages four years and older. (A child must be four years old by September 1 of that school year to be eligible for public school services.) Please refer to Handout 14C to review information regarding PL 94-142.

CONCLUSION

This course has been an overview of some of the topics to be aware of when caring for special needs children.

It is only a beginning and we urge you to take advantage of more in-depth workshops available through Greater Minneapolis Day Care Association (GMDCA) and various other sources.

We want to emphasize that mainstreaming is here to stay. It is not for every special needs child. It is important to distinguish between those children who can be successfully mainstreamed and those who cannot.

The more we know about special needs, the more we realize how much we still need to learn. We hope that by completing this course, you now feel more confident and will continue to be interested in serving special needs children!!! Thank you.

Funding for this project has been provided by the U.S. Department of Education, Division of Handicapped Personnel Preparation, with supplemental funds from the Nevin Huestad Foundation for Handicapped Children, and General Mills.